

TIP 21: Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System: Treatment Improvement Protocol (TIP) Series 21

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The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS for these opinions or for

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What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then communicated to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Chair (or co-Chairs) for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment used in public and private programs recognized for their provision of high quality and innovative treatment.

This TIP spells out a strategy for diverting youth with substance abuse problems from further penetration into the juvenile justice system. Members of the consensus panel have defined a process for communities to use in building new linkages and partnerships among treatment programs, community health and social services, and the juvenile court to plan juvenile AOD diversion programs. All of these collaborators take part in designing the diversion program in which the juvenile justice system and the AOD field are equal partners. They collaborate with many community representatives, who work together to confront the problems presented by juvenile offenders with AOD problems.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

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TIP 21: Chapter1—Introduction

The purpose of this Treatment Improvement Protocol (TIP) is to spell out a strategy for diverting appropriate youth with alcohol and other drug (AOD) abuse problems from further penetration into the juvenile justice system (JJS), by placing them in AOD abuse treatment. Members of the consensus panel responsible for developing this TIP designed a process for communities to use in building new linkages and partnerships among treatment programs, public health services, social services, and juvenile courts in order to plan juvenile AOD diversion programs.

Such partnerships are built by developing consensus regarding the extent of AOD abuse by adolescents in the community, the safety needs of the community, and the array of treatment options required to address the problem. The strategy proposed in this TIP requires each partner to assume responsibility for finding a solution to the problem of AOD-abusing juvenile offenders and for ensuring the overall success of the collaborative efforts of juvenile courts and AOD abuse treatment programs to divert youth away from or out of the justice system.

In recent years, two key factors, the increasingly high number of juveniles involved in crime and the decreasing availability of funding for programs, have reduced the ability of juvenile courts to impose immediate sanctions for juvenile crime. As a result, many JJSs struggle to develop program responses that can meet the complex needs of the youthful offender and the community's need for safety.

A contributing factor to the inability of many JJSs to reconcile often divergent needs is the considerable public concern over the last decade about the prevalence of and increase in violent juvenile crime. Opinion polls indicate that the public has grown less tolerant of many delinquent acts. The JJS was designed to protect and rehabilitate juvenile offenders. Since people in many communities have seen little evidence of successful rehabilitation, they have lost patience. They have thus begun to push for the imposition of adult penalties for juveniles who come before the courts.

Many JJSs struggle to develop program responses that can meet the complex needs of youthful offenders as well as the community's need for safety.

AOD Use: Another Complicating Factor

Juvenile use of AODs presents a fundamental threat to the well-being of children and their families and is significantly associated with serious crime. AOD abuse indisputably is a pervasive and harmful influence; it must be taken into account by juvenile justice planners who seek to balance the needs of court-involved youth, their families, and the community.

Although juvenile courts historically have functioned within a network of community social service and treatment agencies, these networks' responsiveness to AOD-abusing youth has at best inconsistently met the needs of courts, youth, and families. Many AOD abuse treatment programs were developed to serve only those adolescents and families who seek help.

Youth who have severe behavioral or emotional problems may need AOD treatment configured differently from that which is readily available. These special needs, compounded by resistance to treatment, have placed many youth in the JJS beyond the scope of AOD abuse treatment providers.

For all these reasons, judges and staff in juvenile courts may have had little opportunity to see AOD treatment be successful. They also may not fully understand or have much patience with the relapses typical of addiction and the behavior associated with these relapses. Consequently, many judges and juvenile court services personnel seek to remove AOD-using or -abusing adolescents from the community by committing them to training schools, boot camps, or other residential facilities instead of to AOD abuse treatment.

Strategy Needed To Halt Youth Involvement with the JJS

The purpose of this TIP is to articulate a strategy for diverting youth with AOD abuse problems from an escalating involvement with the JJS. Members of the consensus panel responsible for developing this TIP formulated a new approach to designing and implementing a program for

providing AOD treatment to youth who were appropriate candidates for diversion: the AOD abuse treatment system acts as a partner with the JJS and with community health and social services. This approach depends on the development of new linkages and partnerships among these four groups.

This approach contrasts with what often occurs in the justice system, in which plans for treatment are developed and then a treatment program is contacted to arrange for service delivery. The treatment program, in an effort to provide comprehensive services to justice system clients, often refers them to other treatment providers or to public health or social services agencies. Thus, the combined services that youth need often are linked haphazardly, if they are provided at all. The delivery of collaborative and comprehensive care depends to a large extent on the efforts of individual personnel in the treatment system to arrange for it. Juvenile justice personnel are less frequently involved in making formal referrals to public health or social service agencies.

In the model proposed by the consensus panel, treatment personnel and representatives of health and social service agencies in the community participate from the beginning and function as partners with the JJS in designing the program. In this model, these partners collaborate to develop consensus regarding the extent of AOD use by adolescents in the community, the safety needs of the community, and the array of treatment options required to address the problem.

The model proposed in this TIP requires the four partners to share responsibility for the overall success of the collaborative diversion efforts of juvenile courts and AOD abuse treatment programs. The collaborative model requires each partner—the JJS, AOD abuse treatment programs, and community health and social services -- to assume responsibility for finding a solution to the problem presented by juvenile offenders who have substance use disorders.

Definition of Diversion in This TIP

Traditionally, diversion has been seen as a mechanism for removing appropriate youth from the juvenile court process before they are formally adjudicated or even, in some cases, petitioned.

For the purpose of this TIP, however, a broad definition of diversion is used. Diversion, as used in this TIP, refers to an alternative to the further penetration of an individual youth into the JJS. Diversion from formal juvenile court processes may occur at any point within the JJS short of incarceration. For example, a youth may be diverted to AOD abuse treatment informally before adjudication takes place.

Treatment personnel and representatives of health and social service agencies in the community collaborate to develop consensus regarding the extent of AOD use in the community, the safety needs of the community, and the array of treatment options required to address the problem.

A youth may be diverted to AOD abuse treatment after formal disposition; for example, potential commitment to a training school may be held in abeyance until the youth successfully completes treatment. (An equally important need -- programs to divert youth from entering the JJS in the first place -- is also deserving of attention. However, these programs are not the subject of this TIP, which only considers programs for youth who are already involved with the JJS.) *Diversion*, as referred to in this TIP, is a strategy for increasing effective collaboration between the juvenile courts, the AOD abuse treatment field (including public health and social services), and community organizations. It empowers the treatment community with the authority of the juvenile court to require compliance and attendance, while providing the juvenile court with another intervention for juvenile offenders and youth at risk of an escalating involvement in the JJS.

This linkage and collaboration between AOD abuse treatment programs, the community, and the JJS addresses the following needs:

- Individualized screening, assessment, and treatment for young offenders
- The opportunity for youth to be accountable to themselves and the community
- The opportunity for youth to acquire competence in social, vocational, coping, and communication skills and to receive educational services
- The protection of the community.

This TIP provides "hands-on" information and instruction about the process of collaborating to establish a juvenile court diversion program for youthful offenders whose court involvement is associated with AOD abuse. Specifically, this TIP

- Identifies the key issues and policy goals for combining AOD abuse treatment with juvenile justice diversion
- Explores the practical and legal ramifications of this type of diversion
- Provides a greater understanding from a number of perspectives of the opportunities and problems associated with diversion
- Provides communities with a detailed "road map" for collaborative planning and implementation of such diversion programs.

The TIP should be useful to juvenile justice planners, community planners, human service practitioners, and others in addressing AOD abuse in court-involved youth in a multidisciplinary, collaborative manner. The approach to diversion described in this document will be useful in reducing stress on the JJS by encouraging the treatment of AOD-abusing youth earlier and more effectively.

The Center for Substance Abuse Treatment (CSAT) has developed a chart to help planners and others gain an overview of points in the JJS continuum at which collaboration and integration may be most effective. The CSAT Juvenile Justice Treatment Planning Chart is presented in Appendix C.

Description of Chapter Contents

Chapter 2 presents an overview of a diversion program for AOD-abusing youth in the juvenile justice system. It introduces the concept of forming a collaborative group from sources within the community to design and implement the program.

In Chapter 3, the collaborative planning process is described, with emphases on the five major types of decisions that have to be made by the planning group. Four of these decisions pertain to

the community and community organizations: 1) the JJS, 2) the AOD abuse treatment system, 3) community health and social services, and 4) the community itself.

The fifth type—management decisions -- affects the other four and enables the collaborative planning group to bring the diversion program to life. The consensus panel recommends that members of the planning group join forces to address all these areas, with the group most directly affected leading the discussion as appropriate.

Chapter 4 describes the five areas of decisionmaking and presents a systems approach to collaborative planning, leading to a juvenile AOD abuse treatment diversion program.

Chapter 5 presents guidelines for use by the collaborative planning group in its implementation activities and for developing a procedural manual for implementation.

Several appendices follow, providing literature sources and documents that can be useful to planning groups.

TIP 21: Chapter 2 -- Goals of AOD Treatment-Focused Diversion Programs

As the nature of juvenile crime changes, the abilities of State, county, and local juvenile justice systems (JJSs) to manage offending youth are being tested as never before. The public is increasingly concerned about juvenile crime, and society has become less empathetic toward and more critical of the JJS.

Alcohol and other drug (AOD) abuse has become a significant factor in cases referred to juvenile court. Yet AOD abuse in youth is often not recognized as a harmful influence on delinquent behavior; rather, it is viewed with ambivalence or minimized by some youth in an effort to avoid personal responsibility, or it is dismissed as "normal" behavior. Recognizing an AOD abuse

problem can be the key to action by the JJS that may help reduce risk factors and decrease the likelihood of continued offending behavior.

Diverting juveniles already in the JJS away from further penetration into the system has long been a goal of juvenile justice. Today, the diversion of AOD-abusing juveniles into AOD abuse treatment programs is one method of achieving this goal. Under this approach, youth for whom AOD abuse is a problem are placed in treatment rather than incarcerated. If AOD abuse treatment is successful, it helps youths develop skills for daily living and enables them to control their behavior and avoid further penetration into the JJS.

The concept of juvenile diversion can have different meanings for different professionals involved in the process. The prosecutor may see diversion as a means of allowing a youth to avoid legal consequences. For the defense attorney, diversion may mean keeping the youth from being incarcerated. AOD abuse treatment personnel may speak of diversion as an alternative to further enmeshment in the JJS.

In this Treatment Improvement Protocol (TIP), a broad definition of diversion is used. *Diversion*, in this TIP, refers to an alternative to further escalated involvement of an individual youth in the JJS. Diversion from formal juvenile court processes may occur at any point within the JJS, short of incarceration.

Diversion to AOD abuse treatment can occur any time after an offense has been reported or after a complaint or petition has been filed. The purposes of, methods of, and criteria for diversion may differ. Many treatment options are available as part of probation or disposition. Diversion offers the juvenile offender a treatment option that might not otherwise have existed.

The purpose of diversion is not to take away the discretion or power of the court but to use the power of the court to facilitate treatment. The AOD abuse treatment services to which the juvenile offender is diverted must be sensitive to the court's involvement in the treatment process. Treatment staff must understand that diversion to AOD abuse treatment does not extinguish the court's formal authority and oversight over the juvenile. The court gives authority

to the treatment program in which the juvenile is placed, but its role remains central and it may impose further sanctions if the juvenile does not comply with treatment requirements. To be effective, a juvenile AOD abuse treatment diversion program must provide sufficient assurances to the court and to the community that the youth will participate seriously in treatment.

Diversion refers to an alternative to the further penetration of an individual youth into the JJS. Diversion from formal court processes may occur at any point within the JJS, short of incarceration. The purpose of diversion is not to take away the discretion or the power of the court, but to use this power to facilitate treatment.

Diversion to AOD abuse treatment does not remove the juvenile from the JJS. Rather, diversion is an alternative disposition of the case. The authority of the court to impose more progressive sanctions is held in abeyance pending the youth's successful completion of AOD abuse treatment. Discharge from court supervision upon successful completion of treatment can be a strong incentive for some juveniles to participate in treatment. In other cases, diversion to AOD abuse treatment may be only one part of a broader agreement, supervision plan, or court order. For example, restitution or community service may also be mandated.

A Community-Based Approach to AOD Abuse Treatment Diversion

Members of the consensus panel on juvenile diversion to AOD abuse treatment took the position that each community is responsible for its young people and must recognize that the problems of youth reflect the problems of the community. To deal with juvenile crime associated with AODs, all human service systems in a community must collaborate to build on the strengths of the youth, the family, and the community. At a minimum, these systems should include the juvenile courts and AOD abuse treatment services as well as physical and mental health services, the education system, social services, and public policy bodies. All must collaborate as partners in finding solutions. Communities can no longer rely on local AOD treatment services to accept the major responsibility for ensuring that a referred youth receives all the services he or she needs. A thoughtfully developed, collaborative approach is critical.

In many cases, a youth's involvement with AODs may not come to the attention of the juvenile court or court services until late in the youth's delinquent career. Early and accurate identification of a juvenile offender's AOD issues is needed to ensure that appropriate corrective steps are taken. Another TIP in this series, *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, provides useful guidelines for recognizing AOD abuse and providing appropriate interventions.

Within the collaborative partnership, the JJS can provide the influence or mandate to encourage compliance with treatment. For youth, such encouragement is a much-needed tangible support. For communities, a well-planned and clearly articulated strategy of diverting appropriate AOD-abusing youth from the JJS presents three important opportunities:

- The JJS has access to AOD abuse intervention and treatment when needed.
- The AOD abuse treatment community can use the authority of the court to encourage compliance.
- A continuum of services (including AOD abuse treatment services, physical health and mental health care, and other social services) designed to meet the needs of these youth can be brought together in one coordinated plan that responds to the individual youth's multiple needs for treatment and other services.

Characteristics of an Effective Program To Divert Youth to AOD Abuse Treatment

A treatment-focused diversion program for youth with substance use disorders should be the product of a collaborative planning process. Many organizations, ranging from AOD abuse treatment services to physical and mental health and social services, as well as other community organizations, churches, and businesses, can play a role in designing and implementing the diversion program. A continuum of comprehensive services will be needed to provide the level and type of treatment needed by each juvenile referred to AOD abuse treatment. Innovative

approaches will be needed to fund a comprehensive program fully. The consensus panel believes that the collaboration of these organizations is essential to maintaining services during times of limited funding, as such collaboration increases the opportunity to combine or reconfigure services to meet the identified needs of the community's youth.

The following sections address each of the important aspects of a collaborative planning process: creating a multidisciplinary partnership, providing comprehensive screening and assessment, and ensuring adequate funding.

Creating a Multidisciplinary Partnership

An effective program of diversion to AOD abuse treatment depends on collaboration among all the professionals involved in the care and management of substance-using juvenile offenders. These professionals include juvenile court judges, juvenile court services staff, and probation officers; AOD abuse treatment providers; community physical and mental health practitioners; and social services providers to whom the youth may be referred (or with whom the youth already may be involved). Because substance abuse is often a significant contributor to antisocial and offending behavior that leads to juvenile involvement with the JJS, a juvenile court judge must assert community leadership in the collaborative effort.

The local juvenile court judge has the most clearly defined responsibility for youth offenders and is generally perceived as a key leader in the community. The juvenile courts have a unique and vital role in protecting the best interests of youth, families, and communities. The role of the judge should be to help convene, develop, and sustain a community's collaborative effort to develop a program of juvenile diversion to AOD abuse treatment.

In order to develop a collaboration among these groups, each must acknowledge that it has different needs and resources and different responsibilities to the target population. Initially, each collaboration will require strong leadership, either on the part of an individual or a group of key leaders, to bring together all the pertinent agencies, providers, planners, and community

members to encourage and sustain the effort. The effectiveness of this overall effort depends on the success of this initial development process.

Active communication and continuing dialogue among all key parties are essential. Therefore, representatives of each of the groups involved should meet regularly to share information, assess progress, participate in cross-training, and determine future direction. It is imperative that juvenile court judges and court services staff understand the complex issues related to AOD abuse. Defining terms and agreeing upon procedures at the top policymaking level will facilitate the referral of youth to treatment and improve the services provided to them. For example, it is essential that all parties agree on procedures for the release of information that do not violate the juvenile's privacy or confidentiality. Some States require that a parent sign a written consent to release information when more than one type of agency is providing services to a juvenile (see Appendix D, Oregon's Department of Human Resources Multiagency Release).

Before the AOD abuse treatment diversion program is implemented, a consent form should be approved by all systems involved. This form helps establish the formal linkage among all systems dealing with youth and will make it easier to establish an information-sharing protocol that specifies

- The information to be exchanged
- The reason the information is needed
- The way the information will be used
- The agency that will receive the information
- The date on which a consent to release information expires.

For many AOD abuse treatment programs, this effort may be a first-time opportunity to educate members of the collaboration in the extent and scope of pertinent confidentiality laws and regulations. (See the CSAT TIP entitled *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, for a further discussion of confidentiality.)

Providing Comprehensive Screening And Assessment

The earliest possible intervention must be the aim in order to identify the needs of juveniles with AOD abuse problems. Any referral of a juvenile to the JJS should include an initial screening for involvement with AODs and, if indicated, a comprehensive AOD assessment. The initial contact does not have to be formal, such as an arrest or a formal referral to court. For example, in some States, parents who believe their children are abusing AODs may make status referrals of their children to the juvenile court. Whether the contact is formal or informal, a well-designed and smoothly functioning screening, assessment, and referral process must be in place. (In the context of this TIP, "referral" includes placing the youth in appropriate treatment.)

Screening

The consensus panel saw the need for establishing a consistent method for identifying AOD abuse risk factors. Screening should be instituted at the earliest point of contact. The screening can be as simple as a brief decision tree focusing on one or more of several predetermined factors, including the nature of the offense (for example, was it AOD-related?); self-disclosure of an AOD problem by the youth or family; and suspicion based on appearance, language, or intuition. This strategy can be augmented and improved by the implementation of a reliable and valid self-administered screening instrument (Thomas, 1993). (Screening instruments are described later in this chapter.)

Initially, each collaboration will require strong leadership, either on the part of an individual or a group of key leaders, to bring together all the pertinent agencies, providers, planners, and community members to encourage and sustain the effort.

A trained staff member of the court or a certified AOD counselor (who might also be a member of the court staff), mental health counselor, or appropriate personnel from a public clinic may conduct the screening.

Assessment

If the screening identifies a risk of an AOD abuse problem, then a broader assessment should be done to further define the nature and extent of the problem. AOD abuse is considered a

biopsychosocial disease, stemming from biological (physiological), psychological, and social factors. Adolescents' AOD use is embedded in the structure of their families, their peer groups, and their greater social environment. Hence, an AOD assessment should consider physical health, family, educational, economic, mental, and psychosocial status, as well as court history and, in some cases, police record.

Many instruments have been developed to help in assessing the extent and severity of AOD problems in youth. (Navaline et al., 1990).

An AOD assessment should consider physical health, family, educational, mental, and psychological status, as well as court history and, in some cases, police record.

The consensus panel that developed the TIP entitled *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents* recommended that assessment information be gathered in the following critical areas:

- **History of AOD abuse:** Use of over-the-counter or prescription drugs, tobacco, caffeine, or other psychotropic drugs; age of first use; frequency, duration, and pattern of use; how the drugs are taken
- **Medical health history and physical examination:** Previous illnesses, infectious diseases including tuberculosis, medical trauma, pregnancies, HIV infection and other sexually transmitted diseases
- **Developmental issues:** Problems related to psychosocial development
- **Mental health history:** Depression; suicidal ideation or attempts; influences of traumatic events such as physical or sexual abuse; presence of hallucinations unrelated to AODs and the like; summaries of information from evaluation and treatment of mental disturbances, if available
- **Strengths or resiliency factors:** Self-esteem; coping skills; motivation for treatment; support of family, other community supports
- **Family history:** The parents' or guardians' history of AOD use and abuse, mental and physical health problems, chronic illnesses, incarceration, or

illegal activity; traumatic family events; losses of significant people; the family's view of the youth's AOD abuse and ideas about its management; child-rearing concerns; the family's cultural, ethnic, and socioeconomic background and degree of acculturation, if appropriate

- **School history:** Academic and behavioral performance, learning-related disabilities, attendance, available input from the responsible school district
- **Vocational history:** Paid and volunteer work, skills training, and preemployment development
- **Sexual history:** History of sexual abuse, sexual orientation, age of onset of sexual activity
- **Peer relationships:** Interpersonal skills, gang involvement, and neighborhood environment (presence of drug sellers, in particular), significant loss of friends, community and church programs with youth involvement
- **JJS involvement and delinquency:** Types and incidence of offending or delinquent behavior engaged in and attitudes toward such behavior
- **Social service agency program involvement:** Child welfare system involvement (number and duration of foster home placements), residential treatment, informal out-of-home placements made by family or guardian
- **Leisure activities:** Hobbies, interests, presence in community of positive opportunities for participation in recreation, church activities, and organizations such as Big Brothers or Big Sisters.

One individual should take the lead in the process of assessment, primarily to gather, summarize, and interpret data. The designated lead assessor must often call or visit other agencies for information and must work carefully to resolve any "turf" issues between the court and the agency.

The TIP entitled *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents* recommends that the assessor be an appropriate professional trained in and experienced with

adolescent AOD issues -- a psychologist or mental health professional, school counselor, social worker, nurse, physician, substance abuse counselor, or any other individual with responsibility for young people. The assessor should have sufficient experience in evaluating youth with AOD abuse to be able to perform high-quality assessments. If no appropriately trained person is employed by the JJS, then the collaboration should develop a method for supplying this significant service, such as arranging for loaned staff or assessment teams or, when dollars are available, making a purchase-of-service agreement.

If a team of professionals performs different parts of the assessment, one individual should take the lead in the process, primarily to gather, summarize, and interpret the assessment data. The designated lead assessor often must call or visit other agencies for information about the juvenile's history.

Obtaining pertinent information from different people and agencies working with a young person is often difficult. The assessor must work carefully to resolve any "turf" issues while being persistent in gathering information.

The skill level of the assessor should be appropriate to the tasks required by the assessment process. The assessor should be trained in the use of and qualified to administer every instrument in use in his or her agency or office; he or she should participate in regular training updates and continuing education. An unlicensed but trained technician may be able to administer objective assessment instruments such as those described in [Appendix E](#); however, the results may need interpretation and confirmation by a licensed clinician such as a psychologist, a psychiatrist, a certified substance abuse counselor, a psychiatric social worker, or a mental health counselor.

The information obtained via the use of objective assessment tools must be considered in the context of other information gathered during the assessment process to assure an adequate picture of the youth's and family's strengths, needs, and ability to participate in treatment.

The training, education, sensitivity, and skill level of the assessor can reflect directly on the depth and outcome of the assessment. An assessor who is not licensed to make mental health diagnoses should refer a youth in apparent need of a formal psychiatric workup to an appropriate mental health professional. Other professionals should be involved in the assessment process if assessors are not comfortable with or are not trained in particular issues (such as physical or sexual abuse, medical problems, sensitive family issues, or cultural concerns).



Exhibit 2-1 The Assessment Process

Exhibit 2-1
The Assessment Process

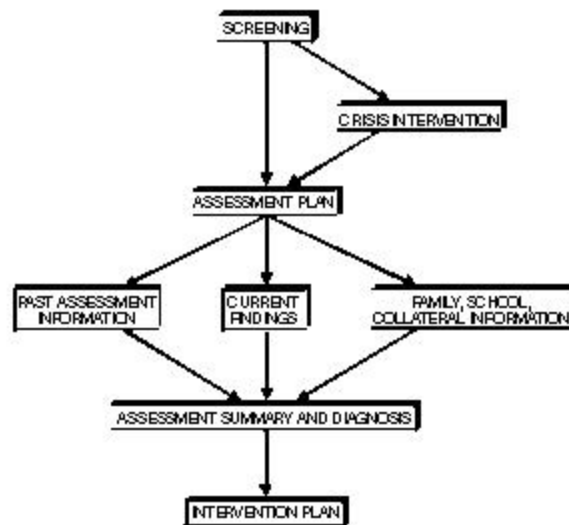
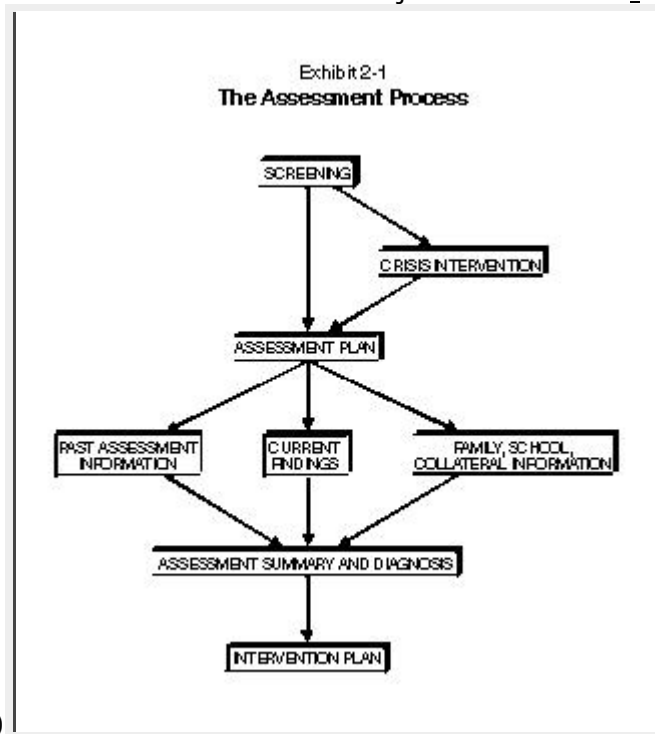


Exhibit 2-1 The Assessment Process

When possible, a summary of information gathered in the assessment process should be included in the juvenile court file with the youth's social records in order to make the information readily available to concerned parties and to avoid repeated assessments that delay intervention. The complex issues of confidentiality may require that a youth and/or his or her legal guardian

consent to having assessment results included in the social records of the juvenile's case file.



(See Exhibit 2-1, The Assessment Process.)

The results of the assessment of the individual youth (and, to the extent possible, of the youth's family) form the basis of the treatment plan or plan of corrective action. If there are gaps in the assessment, the treatment plan will not address important problems. Obviously, the entire process of assessment and AOD abuse treatment will be facilitated if the juvenile court has linkages with various local agencies and programs and can thus guarantee that the youth will be able to move through the whole process with the minimum number of barriers (waiting lists, lack of resources, and the like).

Many communities have limited access to comprehensive assessment services. If this is the case, the juvenile court judge or a juvenile court services staff member may work with other agencies to establish collaborative relationships resulting in purchase-of-service or similar agreements. In rural areas, a "circuit-riding" assessor may be shared by a number of jurisdictions.

Ensuring Adequate Funding

To divert AOD-abusing youth, adequate funding must exist to provide necessary services. The collaboration systems should establish a multiagency management team that includes individuals who are familiar with public and private funding streams. The management team can identify and investigate funding sources from Federal, State, local, and private sources. It is sometimes possible to make creative use of programs that are already funded. For example, a Native American youth who is an enrolled member of a federally recognized tribe may qualify for treatment services through the Indian Health Service at no cost to the diversion program; other youth may be eligible for Medicaid-supported AOD abuse treatment.

Some JJSs have been able to contract with a hospital or other healthcare provider for medical services. School districts may be a resource for all or part of the assessment process. It is hoped that by collaborating, the participating systems may develop creative ways to extend current or decreasing funding levels by clarifying service delivery functions, assessing the need for duplicate services when they exist, developing methods to increase staff productivity, unifying paperwork formats to reduce time and duplication of effort, and blurring program lines to allow for sharing of staff, facilities, or resources.

A variety of funding possibilities should be investigated; such an investigation also may be a way to help families and community groups assume financial responsibility. Revenue sources for funds could be derived from community fees, fines, levies, or forfeitures resulting from drug trafficking and other criminal offenses associated with AOD abuse.

Legislation can create special funds earmarked for or dedicated to AOD abuse treatment programs. The collaborating systems can facilitate access to a broader array of funds than any single group could provide. Representatives of various disciplines can pool their knowledge of resources to obtain funding for needed services. Further, the collaboration has a voice greater than that of a single entity in bringing about changes in current funding streams.

JJS Origins

Juvenile justice in the United States is largely a 20th century phenomenon. For most of the first half of the century, the JJS was envisioned as an informal system within which the youth "who had broken a law or an ordinance [was] to be taken by the hand by the State, not as an enemy but as a protector" (Rosenthal and Smith, 1982).

By the middle of this century, however, there was concern that the traditionally informal nature of juvenile justice could be misused to deny juveniles due process of law. For example, the juvenile courts could place youth in foster homes, assign them to probation, or lock them up in institutions without jury trial or even counsel.

This untenable situation led to a series of Supreme Court decisions that limited the traditional discretionary powers of the juvenile court by increasing a juvenile's rights to due process. The first of these was *Kent v. United States*, 383 U.S. 541 (1966), which stated, "There is evidence that the child receives the worst of two possible worlds: That he gets neither the protection accorded to adults nor the solicitous care and regenerative treatment postulated for children." *The Desktop Guide to Good Juvenile Probation Practice* contains a legal rights section that addresses many of these issues (see Appendix F).

Just as JJS personnel must be aware of current treatment philosophies and approaches to the treatment of youth with AOD abuse problems, so must AOD abuse treatment personnel understand the origins of workings of the JJS.

A series of important U.S. Supreme Court decisions followed *Kent* and clearly defined the parameters of due process afforded juvenile offenders:

- *In re Gault*, 387 U.S. 187 (1967), addressed adjudication hearing, right to notice of charges, right to counsel, and rights of confrontation at hearing.
- *In re Winship*, 397 U.S. 358 (1970), addressed the standard of proof beyond reasonable doubt.
- *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971), declared no right to trial by jury for juveniles.

- *Breed v. Jones*, 421 U.S. 519 (1975), addressed double jeopardy; juvenile adjudication was equated to criminal conviction.
- *Swisher v. Brady*, 438 U.S. 204 (1978), found no double jeopardy in cases involving a de novo hearing (a new hearing, as if the first hearing had never taken place) or supplemental findings by a judge after trial before a master.
- *Fare v. Michael C.*, 442 U.S. 707 (1979), declared that the presence of the probation officer was not required for continuation of police interrogation.
- *Schall v. Martin*, 467 U.S. 253 (1984), addressed preadjudication detention of juveniles and found that preventive detention served legitimate State objectives and that safeguards were required to assure that preadjudicative detention was not punitive in nature.
- *Thompson v. Oklahoma*, 487 U.S. 815 (1988), addressed the death penalty: execution of juveniles under the age of 16 constituted cruel and unusual punishment.
- *Stanford v. Kentucky*, 492 U.S. 361 (1989), also addressed the death penalty: Execution of juveniles aged 16 or 17 did not constitute cruel and unusual punishment.

JJS Goals

The JJS has several basic goals:

- Balanced approach to juvenile court interventions
- Community protection
- Accountability
- Competency development
- Individualized assessment
- Due process protection for youth involved with the court
- Manageable caseloads
- Appropriate dispositions

- Involvement of the juvenile's family
- Community-based interventions
- Victim involvement
- Meeting the needs of youth from special population groups.

Methods for meeting these goals are discussed in the following eight subsections.

A Balanced Approach



Accountability Approach	Reparative	Fair and Proportionate	Active
1. Involvement of the juvenile's family			
2. Community-based interventions			
3. Victim involvement			
4. Meeting the needs of youth from special population groups			

Exhibit 2-2 Accountability Approach

Exhibit 2-2 Accountability Approach

Accountability-based sanctions and supervision may best be described as "reparative," "fair and proportionate," or "active."

Reparative: Drawing upon an ancient tradition of justice that long predates very recent concerns with victims' rights and criminals' "just desserts," the accountability approach gives first priority to the requirement that offenders act to restore loss and repair damages resulting from their offenses. Ultimately, the goal of the justice system is to reconcile victims, offenders, and the community. This reparative or restorative goal is an end in itself. While reducing recidivism and providing rehabilitation are desirable outcomes (and may be the results of the reparative process), justice for both victims and the community is its own reward.

Fair and Proportionate: While compassion and concern for the individual needs of the offender and the underlying causes of the offense may receive

attention, primary emphasis is placed upon the offense, its severity, and the circumstances surrounding it rather than on the personal characteristics of the offender. Fairness demands that, to the greatest extent possible, sanctions be proportionate to the degree of harm resulting from the offense(s).

Active: Unlike both treatment and punitive approaches, which view the offender as a passive recipient of help (treatment) or of unpleasant consequences as a result of confinement (punishment), accountability demands the offender's active engagement. Whereas punishment gives the message to offenders that something will be done "to you" and treatment gives the message that something will be done "for you," an accountability approach asks the offender what he or she will do to "make it right" in the eyes of the victim(s) and the community. In this view, it is the responsibility of juvenile justice professionals and the JJS to provide the monitoring and support services necessary to ensure that offenders are held accountable. This requirement often involves providing offenders with work and community service experience which ultimately increases the likelihood of their future responsible and accountable behavior.

Source: *Accountability in Dispositions for Juvenile Drug Offenders*, 1992.



Exhibit 2-3 Risk Factors

Exhibit 2-3 Risk Factors

- | | |
|---|--|
| <ul style="list-style-type: none">• Community• Availability of drugs | <ul style="list-style-type: none">• School• Early antisocial behavior |
|---|--|

- Community laws and norms favorable to drug use and crime
- Media portrayals of violence
- Transitions and mobility
- Low neighborhood attachment and community disorganization
- Economic and social deprivation
- Family
- Family history of the problem behavior
- Family management problems
- Family conflict
- Favorable parental attitudes and involvement

- Academic failure in elementary school
- Lack of commitment to school
- Individual/Peer
- Alienation, rebelliousness
- Friends who engage in the problem behavior
- Favorable attitudes towards the problem behavior
- Early initiation of the problem behavior
- Constitutional factors

Source: Adapted from *Communities That Care: Risk-Focused Prevention Using the Social Development Strategy*, 1994.

Community protection, accountability, competency development, and individualized assessment are the basic values identified by (see [Exhibit 2-2](#) , Accountability Approach).

The challenge to juvenile courts over the years has been to reconcile these seemingly incompatible values in order to develop a strategy that will address the needs of the community, the juvenile courts, and the youth processed by the courts. Justice is best served when the

community and the youth receive balanced attention and each gains a tangible outcome from interaction with the juvenile court.

The basic components of the balanced approach and some intervention options associated with them are

- **Community Protection and Public Safety:** The public has a right to a safe and secure community. Accordingly, a primary goal of the juvenile court system is to protect citizens from crime.
- **Youth Accountability:** Whenever a juvenile commits an offense, there must be a tangible and enforceable consequence for the misdeed. The juvenile must accept responsibility for the loss, damage, or injury suffered. Procedures and techniques to enhance the youth's accountability for wrongdoing while maintaining a rehabilitation orientation must exist.
- **Competency Development:** Juvenile offenders who come within the jurisdiction of the court should leave the JJS more capable of living productively and responsibly within the community. Approaches to achieving this goal include traditional rehabilitation and treatment programs. More recently, efforts have focused on basic habilitative processes, including those that enable youth to develop social competency, parenting skills, and independent living skills, and to acquire vocational training and job skills.
- **Individualized Assessment:** Each young person entering the JJS is unique. Consequently, the youth's social and cultural surroundings, background, circumstances, talents, and deficiencies all need to be examined on an individual basis. Individualized assessment takes many forms, including 1) the placement of the youth in different legal categories, 2) the performance of diagnostic assessments to determine appropriate treatment response, 3) the development of differential caseload assignments based on risk of further offenses and danger to the

community, and 4) the development of treatment case planning strategies based on a multitude of variables that address both risk and need.

The JJS is responsible for providing the accountability-based sanctions and supervision necessary to ensure that juvenile offenders are held accountable. To ensure the safety of the community, juvenile offenders who are a potential threat to the community should not be eligible for diversion to AOD abuse treatment. A range of supervisory options must be available within the community so that each juvenile can be monitored based on his or her level of risk to the community (Bazemore, 1992a).

Accountability is achieved when juveniles accept responsibility for their behavior. The JJS's response to the offense must make it clear to the juvenile that the act was dangerous and resulted in loss, damage, or injury and that the juvenile is expected to make restitution to the community. In turn, the community must be sensitive and responsive to the needs of juvenile offenders and their families.

Not all juveniles have the interpersonal and cognitive skills necessary to accept responsibility and be accountable for their behavior. Many youth also lack basic education and social skills such as anger management or conflict resolution. Diverted youth should be helped to develop the skills required to become productive members of society.

Due Process for Juveniles

Although the statutory rights of juveniles in the JJS vary from State to State, all juveniles' rights of due process must be protected. Although youth who commit drug-related crimes in some States have a right to referral for treatment, the fact that the agencies to which they are referred can actively deny them admission diminishes their right to treatment.

Juvenile offenders should not have an automatic right to diversion, but due process for these juveniles should include an objective, centralized assessment and clearly articulated eligibility criteria for placement in a diversion program. The offense should be just one of several criteria

when the possibility of diversion is considered. Other criteria will be explored later in this document.

Juveniles should have a guardian *ad litem* (a guardian for the particular proceeding) or legal representative when they are being considered for diversion to treatment -- not only to protect their traditional due process rights but also to explain dispositional options and their consequences. For example, a youth being considered for diversion may have to choose between 6 months of probation with the juvenile court or a full year of treatment. Some programs require a juvenile who is charged with a drug offense to admit to the offense before being sent to a diversion program, and the juvenile in this situation needs a full explanation of the potential consequences of such an admission.

In re Gault 387 U.S. 187 (1963) underscored the importance of representation of juveniles by counsel. Now most States provide by statute for representation of juveniles by counsel in one form or another. Statutes vary. Some jurisdictions require that the guardian *ad litem* be an attorney, especially if the juvenile faces the possibility of commitment to a correctional institution. Other jurisdictions may allow the guardian *ad litem* to be someone who understands the JJS and acts in the best interest of the youth. The guardian *ad litem* must be mindful that the privilege against self-incrimination applies to juveniles. While his or her responsibility is to advocate for the youth's welfare, as well as to provide legal assistance, the guardian *ad litem* must have some discretion regarding the appropriate way to handle information that a juvenile volunteers about offending or criminal behavior unrelated to the offense for which the juvenile has been brought into the JJS. Furthermore, the guardian *ad litem* should be sensitive to cultural issues and have sufficient rapport with juveniles to allow him or her to establish and maintain their trust.

Accountability is achieved when juveniles accept responsibility for their behavior. In turn, the community must be sensitive and responsive to the needs of juvenile offenders and their families

Prompt response by the JJS is extremely important to increasing the effectiveness of AOD abuse treatment. An AOD-abusing youth is most susceptible to successful intervention when he or she

is in crisis, that is, immediately after being taken into custody and detention. A timely and systematic AOD screening and assessment is necessary. The AOD-abusing youth should be subject to immediate referral to appropriate AOD abuse treatment. Too often, delays in imposing interventions for juvenile offenders are protracted. Timely and effective resolution of cases involving AOD abuse is particularly critical if the AOD abuse treatment diversion program is to establish and maintain credibility in the community.

Due process implementation often varies according to who the offender is, where the offense occurred, and the type of offense. Clear and concise procedural guidelines should be developed to incorporate due process rights for every juvenile. The existence of guidelines will facilitate the process and help keep JJS and AOD abuse treatment personnel aware that they must remain conscious of the juvenile's rights throughout the process.

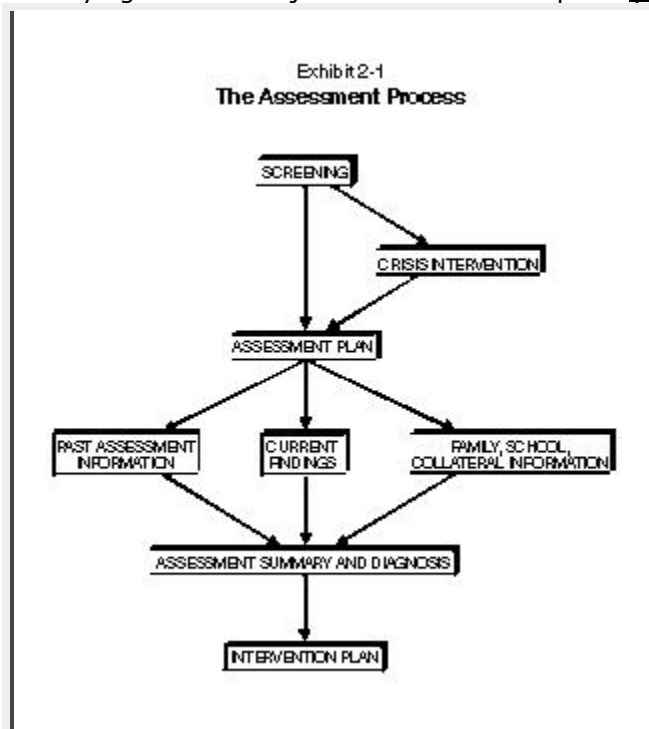
Management of the Juvenile Justice Caseload

Productive case management by the JJS is one of the primary features of an effective system of justice for juveniles. Readers should note that both the AOD abuse treatment field and the JJS perform case management. The use of the term "case manager" can be confusing when the two work together. It is important to designate whether one is referring to case management of clients in AOD abuse treatment or to case management of offenders within the JJS.

Individualized assessment, classification, and case planning are cornerstones of effective JJS case management. Individualized assessment is necessary for effective case management: An assessment must be made of the juvenile's risks and needs and of available resources. Any causes or factors that influenced the youth toward high-risk behavior must be assessed as well as what factors can be used in a positive movement toward law-abiding behavior. The critical areas in the juvenile's life -- the family, the school, and the community as well as the social, interpersonal, and job skills necessary for those interactions -- must be assessed (National Institute for Juvenile Justice, 1993).

Case classification in the justice system is a management tool designed to assess a client's risk and needs and then to assign resources accordingly. Not all juvenile offenders exhibit the same risk factors or require the same level of supervision (Baird et al., 1984).

Whether the initial AOD assessment within the JJS is conducted formally or informally, the information gleaned during the assessment should be applied directly to a case plan for holding the juvenile accountable for his or her actions, ensuring the safety of the community, providing reparation to the victim, and identifying treatment objectives for the juvenile. Confering with a designated representative of the AOD abuse treatment system will be a necessary step in identifying the AOD objectives for the case plan. (See Exhibit 2-1, The Assessment Process.)



The case plan should identify both long-range and short-range objectives. One well-known JJS case planning strategy assists the juvenile intake officer or counselor in selecting the most appropriate problems for immediate attention and involves the following components identified by Lerner et al. (1986):

1. Analysis/identification of the problem and the youth's strengths and weaknesses

2. Problem prioritization based upon **strength** (is the problem an important force in the juvenile's delinquency?), **alterability** (is the defined problem subject to modification?), and **interdependence** (will solving this problem help solve other problems?).

The caseload of a juvenile court services officer depends upon a variety of factors, including the number of youth referred to the juvenile court, the number of juvenile court services officers available to handle the cases adjudicated by the court, the officers' individual responsibilities, and their qualifications and areas of specialization. For example, some juvenile court services departments have units that handle only specialized cases such as youth with AOD problems or sex offenders.

In addition, some juveniles require intensive supervision or frequent drug screens and may be subject to daily contacts with juvenile court services officers. These officers, especially case managers in large rural geographical areas, may have to spend a significant amount of time traveling. Many juvenile court services officers are involved in preadjudicatory court activities in addition to their responsibility for managing cases of adjudicated delinquent juveniles.

As most JJS practitioners know, a single case manager is needed to coordinate activities and to answer any questions that arise concerning the juvenile's progress and behavior. A designee of the court, perhaps the juvenile court services officer, may be the most appropriate case manager; however, it is not required that the case manager be a designee of the court.

In fact, some people believe the case manager should not be a designee of either the juvenile court or of AOD abuse treatment services. The affiliation of the case manager selected to handle an AOD abuse case will depend on the resources available to the community and the agencies serving it. Regardless of the approach followed, it is important that representatives from all the groups involved in the collaboration agree on the designation of the case manager.

Ideally, a mechanism should be established for selecting staff to work with each youth. For example, the Norfolk Interagency Consortium (NIC) in Norfolk, Virginia, was created to establish

a proactive interagency approach to the provision of intensive treatment services through a comprehensive collaborative system of individual care. The NIC's stated mission is To preserve the family and its individuals, by linking youth and their families with community-based resources to strengthen the family and to enhance the self-esteem and integrity of all family members.



Exhibit 2-4 City of Norfolk's CAPES Program Community (more...)

Exhibit 2-4 City of Norfolk's CAPES Program Community Services Board

Chemical Abuse Prevention Through Educational Services (CAPES)

The CAPES Program, a community-based early intervention program, is designed to divert first-time offenders of substance abuse (ages 8-18) from the Norfolk Juvenile and Domestic Relations Court by the provision of educational/counseling services. This program was originally proposed by the Community Services Board in 1984; however, Family Services was selected to implement CAPES and had responsibility for its operation until recently. The program is now back with Norfolk Community Services Board's Office of Prevention and Information Services.

Educational groups are conducted for 20 hours with a maximum of 9 participants per group. They are closed ended. The groups meet for 2 hours, 5 times a week for 2 weeks. Youth are placed in age appropriate groups, i.e. young groups ages 8-13, older groups ages 14-18. The subject material includes drug specific information; drugs and health related information; drugs and the law; decision-making; self-esteem; communication skills;

peer pressure, alternatives to drugs; coping with emotions and change to include anger management/conflict resolution; social responsibility; cultural issues, etc. The format is experiential in nature, requiring active participation.

The CAPES Program provides 6 parent support/education groups during the 2-week period. Parents are required to participate in at least 4 groups. Two communication building group sessions requiring the simultaneous participation of both parents and youth are also provided.

Three individual counseling sessions are provided to each student. Youth in need of more than 3 sessions are referred to the Adolescent Substance Abuse Outpatient Program. The schools reinforce the diversion into CAPES by making it mandatory that satisfactory completion of this program is required prior to re-entry into the school and insure that all first offenders are reported to the youth bureau.

The CAPES Program has proven effective in diverting first-time offenders from the courts and successfully returning them to school. With the Student Assistance Program in all Norfolk High Schools and 3 Middle Schools, the Student Assistance Counselors are able to provide long-term followup, further increasing the effectiveness of the CAPES Program. Early intervention by the CAPES Counselors and Student Assistance Counselors will have a positive affect on adolescent first-time users in the City of Norfolk.

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Exhibit 2-5 Family Involvement

When possible, parents should participate in all the required phases of their child's treatment. Since most AOD-abusing adolescents live in problematic families, these families should also agree to enter treatment. Parental education groups and nuclear family therapy should be part of the adolescent treatment program. AOD abuse, sexual abuse, violence, and criminality are intergenerational and should be treated as such in an attempt to stop dysfunctional patterns. Parents should be helped to deal with their own AOD abuse, sexual abuse, and other issues that perpetuate family dysfunction. Parents must be engaged, empowered, and helped to see their roles as part of the solution, not just as part of the problem. They must relearn parenting skills in the context of proactive parenting designed to best help the adolescent with AOD problems.

Source: CSAT TIP, *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, 1993.

To achieve this mission, the city of Norfolk has established a case management system that uses community assessment teams (CATs) to determine appropriate interventions for selected youth and to provide the most proactive, innovative services possible to the city's youth and families. The members of the CATs represent the following agencies: the Division of Social Services, mental health agencies, Juvenile Court Services, the Juvenile Services Bureau, the public school system, AOD abuse treatment providers, public health services, parents, and private service providers Exhibit 2-4 , Norfolk's CAPES Program. It describes the *Chemical Abuse Prevention Through Educational Services* [CAPES] program of the City of Norfolk Community Services Board.)

The availability of alternative methods of supervision and support is also a factor affecting caseload management. In the Denver Juvenile Treatment Alternatives to Street Crime (TASC) project, for example, a community-based "tracker" may remain in contact with a juvenile who

needs a lesser degree of supervision, stay informed of the juvenile's location, and ensure that the juvenile attends treatment sessions. This work leaves a certified addiction specialist affiliated with the Denver TASC free to work one on one with the more unresponsive juveniles.

Appropriate Dispositions

Diversion should not be viewed as a vehicle for the youthful offender to avoid responsibility.

Accountability under the law is essential. The JJS is required to mandate sanctions and remedies for unlawful behavior and, in some cases, to provide treatment services to avert further offenses.

Diversion should be viewed as an appropriate disposition, taking into full account a clearly defined problem requiring treatment. Clearly, the AOD-abusing youth must be held accountable for his or her conduct if rehabilitation is to be successful. The court's power and authority to mandate treatment for AOD abuse can be a significant asset to support the treatment process.

Accountability in juvenile court dispositions addresses the identified needs of the juvenile as well as the needs of the family and community. Those juvenile courts and court services making effective dispositions will recognize not only the risks associated with an intervention but also the strengths of the juvenile, family, and community. For example, it may be inappropriate to allow an adjudicated youth with an identified AOD abuse problem to remain in a community in which there is little bonding among the members and in which values and mores support AOD abuse. The youth may be better served in a community-based placement outside his or her home community.

It is best to make dispositional recommendations based on individual needs. The consensus panel recognized that, unfortunately, these recommendations are often made on the basis of the availability of services and resources. The community is the key to successful reduction of AOD abuse. Every community should develop and sustain comprehensive substance abuse prevention, treatment, and recovery programs for youth and families. The community is in the most effective position to develop and sustain accessible programs that over time will successfully prevent, treat, and control substance abuse. However, when the resources that the juvenile needs do not exist, it will be necessary to develop them or obtain them from other

sources, including other jurisdictions. The community must set priorities and reach out to find or develop the resources. Providing treatment alternatives is a responsibility of society to its juveniles. Every community must define the extent and nature of juvenile AOD abuse to determine the precise nature of the problems it must confront in dealing with AOD-abusing juveniles.

In some cases, there are resources within the community, particularly in urban communities, but uncovering them takes considerable effort. The best resources are the parents, the relatives, the people, and the organizations (such as churches, schools, or recreation programs) within the community. These people and organizations may be natural helpers, and obtaining assistance from them usually does not require additional funding.

Family Involvement

With a parent's natural right to control a child's upbringing comes the responsibility to discourage AOD abuse by the child. Family involvement is critical to effective juvenile court interventions. It is particularly critical in the treatment of court-involved youth who have AOD abuse problems (Geismar and Wood, 1986).

The traditional definition of a family is not necessarily applicable to the case of every juvenile. Alternative and functional family arrangements should be fairly and honestly considered during efforts to involve "family" in juvenile court interventions. For example, a stable family may consist of a grandmother and her grandchildren, a single mother living with her boyfriend who may be helping raise the children, or foster parents raising children from several different families. The National Association of Social Workers' Commission on Families defines the family as "two or more people who consider themselves family and who assume obligations, functions, and responsibilities generally essential to healthy family life." The functions of family life include child care, child socialization, income support, long-term care, and other types of caregiving.

The family is the most critical force for control, authority, and support in the lives of children and adolescents. When parental substance abuse is determined to be a factor contributing to familial

dysfunction, the family is likely to need treatment services as well. In some States, treatment for families can be ordered by the court; however, it should be noted that these orders may not extend to individual parents.

Rather than relying only upon the authority of the court, diversion programs may find it necessary to identify other means of obtaining the participation of the family in treatment either for the juvenile or for themselves. For example, an explanation of how their involvement can help the juvenile may be required in order to garner the cooperation of family members. AOD abuse treatment providers should initially seek to engage parents or guardians as "members" of the treatment team. This role alleviates the sense of helplessness and feelings of guilt and anger many parents experience.

Resistance to treatment often comes from the fear that treatment will intensify undesirable feelings. Any court-ordered requirement and treatment expectation must be feasible for the family to meet. The flexibility to make and support accommodations—such as providing court time as well as treatment outside working hours, providing transportation assistance, and making bilingual or bicultural staff available to provide gender-specific treatment -- is essential for successful AOD abuse treatment of the youth.

Although the primary goal should be family preservation, it may not be possible (or even always advisable) to keep the family intact at all costs. Sometimes the family environment is abusive, and remaining in or returning to that environment is not in the best interests of the youth -- return may not even be safe. If the juvenile's safety from physical, sexual, or severe emotional neglect or abuse cannot be guaranteed, alternative arrangements must be considered. If it is necessary to remove the juvenile from the home or community, the time that the juvenile remains away from the home should be as brief as possible. During this period, case managers should work with the family and the juvenile to prepare them both for the juvenile's return. Building on the family's strengths will promote family preservation.

Differences in cultures, values, family systems, and dynamics must be respected. No single measure of family functioning should be used to determine the "worth" of the family or the

ability of the parent. The juvenile court must be guided by the balancing of three interests: the safety of the youth, the role of the parents, and the responsibility of the State.

Community-Based AOD Abuse Treatment in Least Restrictive Setting

AOD abuse treatment within the context of the community's needs should be a primary goal of juvenile justice interventions. Community-based AOD abuse treatment has the advantage of allowing the family access to treatment and providing continuity of care, as the same people work with the juvenile throughout the treatment process and establish a support system for the juvenile. This approach facilitates community responsibility to the juvenile and empowers the community. Furthermore, placement in the community can help make the juvenile more socially conscious and encourage him or her to make decisions appropriately and independently.

Juveniles should be placed in the least restrictive community environment during AOD abuse treatment; this placement requires a careful screening and assessment to ensure that the juvenile will not be a threat to the safety of the community. Therefore, some community-based treatment alternatives should exist that directly address these issues and that maintain public safety and hold the juvenile accountable without incarceration (placement in a secure facility). Such alternatives may include intensive treatment with electronic monitoring, as in the Clackamas Juvenile Justice Collaboration, or the use of a tracker, as in the Denver TASC project. If incarceration is necessary, it should be meaningful in the sense that its structure should help the juvenile increase his or her social competency, become more accountable, and return to the community as promptly as possible.

It is important to build upon the community's strengths. Programs that reflect positive community values and in which the community has demonstrated support should be considered prime candidates for funding. Referring AOD-abusing juveniles who have committed AOD-related or other offenses to such programs can reduce the problem of "labeling," because such referral prevents the identification of these juveniles as part of a special group.

Some community-based treatment alternatives should exist to ensure that the juvenile will not be a threat to the safety of the community.

Victim Involvement

An emerging shift in the JJS has established the victim of a crime as a "client," on an equal footing with both the community and the offender. Today, more and more people recognize that when a person commits an offense, he or she incurs an obligation to the victim. Accordingly, juvenile justice interventions should attempt to restore to the victim and to the affected communities that which has been lost as a result of the juvenile offender's actions. To accomplish this goal, victims must be empowered as active participants in the juvenile justice process. Victim reparation is accomplished through several well-established practices, such as restitution, community service, and victim-offender mediation. Victims can play an active role in providing input into the system, ensuring appropriate reparation, and making the offender aware of the damage for which he or she is responsible (Bazemore, 1992).

Furthermore, because one of the primary goals of the JJS is to return the juvenile offender to the community and because it is preferable for AOD abuse treatment to take place within the community, it is entirely possible that the juvenile will encounter the victim eventually. In some instances, a meeting between the juvenile and the victim, orchestrated by court services personnel, may help the juvenile realize the extent to which he or she has done something wrong. It makes the crime less impersonal and forces the juvenile to consider its consequences.

In some instances, as in the case of informal adjustments, it is appropriate to involve the victim in the disposition of the juvenile's case. In fact, the involvement of the victim may empower members of the community to care for their own. However, the potential involvement of the victim should not indicate either a bias in the system or a differential valuation of either the victim or the juvenile offender. For example, regardless of the individual characteristics of the victim, the sanction for the offense should be the same.

The type of offense is significant in determining the feasibility of victim involvement. When the offense is a property offense that may be settled through mediation, a meeting between the victim and the juvenile may be useful. In the case of an offense such as rape, however, such a meeting may be inadvisable. The background and maturity of the juvenile, as well as the degree of harm done to the victim, also influence whether the victim should be involved in the juvenile's case. Even when the victim does not meet with the juvenile offender and does not participate in the legal proceedings, the JJS should have a mechanism to inform the victim about the disposition of the case.

Needs of Juveniles from Special Populations



Exhibit 2-6 Gender-Specific AOD Abuse Treatment

Exhibit 2-6 Gender-Specific AOD Abuse Treatment

Treatment programs serving pregnant, AOD-abusing adolescents include the following services, or support active outreach to and linkage with appropriate service resources already available in the community:

- Comprehensive inpatient and outpatient treatment on demand.
- Comprehensive medical services.
- Gender-specific services that are also ethnically and culturally sensitive. These services must respond to women's needs regarding reproductive health, sexuality, relationships, and all forms of victimization. Services should be offered in a nonjudgmental manner and in a supportive environment.
- Transportation services, including cab vouchers, bus tokens, and alternatives for women who live in communities where

public transportation is cumbersome, unreliable, or unsafe.

- Child care, baby-sitting, and therapeutic day care services for children.
- Counseling services, including individual, group, and family therapy.
- Vocational and educational services leading to training for meaningful employment, the General Equivalency Diploma (GED), and higher education.
- Drug-free, safe housing.
- Financial support services.
- Case management services.
- Pediatric followup and early intervention services.
- Services that recognize the unique needs of pregnant, adolescent, substance users.

Source: CSAT TIP, *Pregnant, Substance-Using Women*, 1993.

Youth involved in the JJS represent the full spectrum of socioeconomic, cultural, and ethnic categories, and physical ability. As a result, the services and interventions provided by the JJS must meet the cultural, spiritual, physical, mental health, language, and gender-specific needs of a wide range of juveniles (see Exhibit 2-6, Gender-Specific AOD Abuse Treatment).

Traditionally, it has been more difficult to obtain services for juveniles with special needs than for those without such needs. Some juveniles, as a result, have been excluded from the particular program that they need because of that program's narrow focus. The continuum of AOD abuse treatment services available to diverted youth should be matched to serve the spectrum of needs identified by the community collaboration. The collaboration should consider how best to serve youth

- Who have disabilities (such as learning disabilities, emotional disturbance, mental retardation, and physical impairment)
- Who have a coexisting mental disorder

- Who have been victims of abuse
- Who are living at a low socioeconomic level
- Who are homeless
- Who have educational deficit(s)
- Who are pregnant and/or parenting (including teen fathers)
- Who are gang members
- Who are latchkey children
- Who are gay, lesbian, or bisexual
- Who are not Caucasian
- Who are from cultures other than the dominant one(s) of the community
- Who are in the country illegally and/or whose parents are undocumented workers
- Whose parents are migrant workers
- Whose parents are mentally ill
- Whose parents are involved in the criminal justice system
- Whose parents abuse AODs.

It may be necessary to be imaginative and creative in order to develop the resources required to meet the needs of these special groups. For example, the primary (often the only) language of a substantial number of youth in the JJS is not English. AOD screening and assessment instruments may not be available and normed in the language of non-English-speaking populations (such as Spanish, Laotian, or Vietnamese). Involving community leaders and parents in the design of a screening tool may produce more sensitive instruments and bring the community more fully into the partnership. Many AOD screening and assessment tools, including those available in several languages, have not been normed for every cultural or ethnic group. Also, many tools are not translated in a manner that is culturally appropriate for certain groups.

Where no appropriate tools exist, a comprehensive interview by a bilingual or bicultural professional should be sufficient. The relevant research regarding the specific target populations should be reviewed before an instrument or method of treatment is selected. In addition to the

screening and assessment instruments, the AOD abuse treatment modalities available must be culturally, ethnically, and spiritually relevant to all populations, including minorities. See Appendix G, *Multicultural Awareness: Developing Cultural Understanding of the Juvenile Justice System*.

Gay and lesbian youth are at high risk of AOD abuse, and some research has shown that their rates of alcoholism may be three times that of the general population (Feinleib, 1992). AOD abuse treatment service providers need to be aware of the special needs these youth bring into treatment. Staff members should be comfortable discussing sexual orientation issues and conscious of the conflicts that may arise in mixed treatment settings. Homophobic behavior occurs frequently in the greater society and could easily exclude gay or lesbian youths from the potential benefits of AOD abuse treatment.

Adolescent Treatment Goals

AOD abuse treatment for youth was covered by the CSAT consensus panel that developed the *TIP Guidelines for the Treatment of Alcohol- and Other Drug- Abusing Adolescents*. That panel was charged with producing guidelines to be used by States for the establishment, funding, operation, monitoring, and evaluation of treatment programs for AOD-abusing adolescents. An additional effort was made to define treatment approaches to meet the specific needs of AOD-abusing adolescents involved with the juvenile and criminal justice systems.

The fundamental assumptions underlying the TIP included

- Adolescent clients require different core treatment services from adult AOD abusers. Services must focus on age-appropriate skill development.
- Among these needed services are screening, assessment, and diagnosis; matching the client with the appropriate type and intensity of treatment, which should include a variety of behavioral, cognitive, and family therapies; preventing relapse; providing continuing care; and developing skills that are necessary to a successful, independent life.

- Ancillary services for AOD abusers should be tailored to meet the specific needs of adolescents. Services include specialized education, preemployment training, health maintenance, transportation, leisure activities, and mentoring.

Adolescent AOD Abuse Assessment Criteria



Exhibit 2-7 Indicators for Assessment

Exhibit 2-7 Indicators for Assessment

- | | |
|---|--|
| <ul style="list-style-type: none"> • Physical or sexual abuse • Parental AOD abuse • Parental incarceration • Poor school performance or attendance • Physical symptoms of AOD abuse or adverse consequences of AOD abuse • Peer involvement in AOD use or serious crime • Marked changes in | <ul style="list-style-type: none"> • Involvement in serious delinquency or crimes • Dysfunctional family relationships • Serious problems at work (e.g., losing a job) or in school • HIV high-risk activities (e.g., injecting-drug use; sex with injecting-drug user) • Indicators of serious physical problems (e.g., suicidal ideation, severe depression). |
|---|--|

physical health

If the brief screening suggests the existence of a problem, then assessment for AOD abuse is necessary (see [Exhibit 2-7](#)). Many States, including Oregon, Iowa, and Washington, have developed AOD abuse treatment system "levels of care," and others have adopted the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM). These systems help practitioners determine the need for a specific intensity of treatment for each individual through the use of identifiable markers relating to the need for detoxification, treatment resistance, coexisting emotional and behavioral problems, and relapse potential. Such patient placement criteria provide greater consistency of treatment recommendations among assessors, whose clinical judgment, rather than personal relationships or the influence of good marketing, should dictate treatment recommendations. (See the CSAT TIP *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders*.) The criteria make it possible to place youth in AOD abuse treatment programs that provide the intensity of services they need.



Exhibit 2-8 Continuum of Service

Exhibit 2-8 Continuum of Service

- | | |
|--|---|
| <ul style="list-style-type: none">• Prevention• Early Intervention• Outpatient Treatment | <ul style="list-style-type: none">• Intensive Outpatient Treatment• Residential Services |
|--|---|

Ideally, a full continuum of AOD abuse treatment services should exist in each community (see [Exhibit 2-8](#), Continuum of Services). Rarely, however, is this the case. The full continuum ranges from low intensity services for youth in the initial stages of AOD abuse problems to high-intensity services for those with severe problems. It is the task of the collaboration to identify service gaps, to assist the AOD abuse treatment provider group in reorganizing parts of the existing

system, and to obtain additional funding to fill in the gaps identified. Many juveniles in the diversion program will have had previous AOD abuse treatment experiences, and some may have a significant history of delinquent behavior. To ensure positive treatment outcomes, sophisticated programming must be developed that can confront the thinking errors and treatment jargon that juveniles may have learned.

Each service level encompasses many types of prevention or treatment settings. Prevention can range from neighborhood protection efforts to peer helper programs in schools. Outpatient treatment can be located in a school or community center or can function as a free-standing agency.

The science and technology of AOD abuse treatment is constantly moving toward a clearer understanding of which forms of treatment work for which parts of the population. The collaboration should undertake a review of the pertinent treatment literature when considering the local service continuum.

The current body of research findings is too large to review adequately in this document. Access to this information has been greatly enhanced by the availability of computer network links to online databases. Many university systems have developed rural networks to ensure access to information and technology.

The consensus panel felt that successful treatment of AOD-abusing juveniles required families and the community to be dynamic parts of the treatment. No matter how conflicted family relationships appear, juveniles are still part of the family units, and AOD abuse treatment needs to focus on these units, not just on individual juveniles. The concept of adolescent AOD abuse treatment should be expanded from informational lectures and self-help. It should focus in addition on each juvenile and his or her family and peer group. Family treatment can be provided in many ways:

- **In-home intensive intervention such as providing information about family preservation models.** This type of intervention seeks to

increase the parents' skill in managing house rules, communication, and consistency in consequences.

- **A multifamily education and treatment group designed to empower parents.** This type of intervention seeks to help parents resolve issues and to share successful interventions and skills.
- **Family network therapy.** This type of intervention engages the extended family and close social support in developing solutions to the identified problems.
- **All forms of individualized family therapy techniques.**
- **Family AOD education.**

A family's involvement may be hampered by parents' fears that treatment professionals will blame them for their children's problems. Family members should participate in identifying problems and planning treatment. Providers should actively attempt to involve the family even if the youth is not currently living at home, except in cases where the family presents a clear risk of physical, sexual, or emotional abuse. Involvement can be as minimal as phone contact regarding progress in treatment. However, this minimal level of involvement should serve as a fallback strategy only after the family has refused more intensive participation.

Using only a single family intervention model may not be helpful. Many family therapy models are based on concepts of how a functional family is structured and how roles are determined in order to maintain the structure. For many segments of the population, these therapies may not support the cultural family structure or may be viewed as overly intrusive.

Peer groups can be affected through school- or community-based interventions as well as through more traditional group therapies. Adolescent group therapy offers the opportunity for the development of new social, problem-solving, and anger management skills. Furthermore, it allows juveniles to interact in an arena in which they can receive feedback on how they relate to other adolescents. Group therapy also allows for the introduction of information regarding alcohol, tobacco and other drugs, human immunodeficiency virus (HIV), tuberculosis (TB), and other health concerns.

Adolescent AOD abuse treatment should also include individual therapy. This modality allows for continued assessment of coexisting mental health issues, privacy for the adult therapist to provide feedback regarding inappropriate behaviors, and a forum in which youth can bring up issues that they feel the group may not understand, such as specific fears, gender issues, details of sexual or physical abuse, or health issues. This relationship is often the bond the youth needs to feel safe in treatment.

Many youths enter AOD abuse treatment with physical problems, such as untreated injuries, pregnancies, and acute illnesses. Forming linkages will facilitate referrals for medical care. The medical providers with whom linkages are formed should have a history of successfully treating adolescents.

Criteria for Admission to AOD Abuse Treatment Diversion Programs

Substance-using juvenile offenders who qualify should be diverted into AOD abuse treatment at the earliest possible point. Clear and concise guidelines must exist to determine who is eligible for diversion programs and to ensure equitable treatment no matter who the juvenile is and no matter where the juvenile is in the justice system. These guidelines must incorporate and protect the juvenile's due process rights.

While meeting the requirements of providing for community safety, AOD abuse treatment diversion programs should be designed to include only minimal barriers to admission. Thus, the goal should be to channel as many youth as possible into treatment rather than to screen out as many as possible. AOD screening and assessment are critical to determining which youth are appropriate for diversion to AOD abuse treatment.

Adolescent AOD Abuse Treatment

Adolescents constitute a diverse group. AOD abuse treatment programs that are able to meet their full spectrum of needs are rare. Healthcare reform and other external influences are shifting the emphasis in AOD abuse treatment placement decisions. Matching clients' individual clinical

and other problems with the most appropriate level of AOD abuse treatment is emphasized, rather than providing accountability sanctions or long-term child welfare services.

Because relapse, while expected, places the juvenile in jeopardy, it is wise to hold an initial case conference that includes the juvenile, the parent(s), the AOD abuse treatment providers, and representatives of the JJS early in the treatment process. Such a meeting provides an invaluable opportunity to assess the juvenile's progress and to redefine the consequences that will be imposed if the youth relapses.

Continuing Care

To prevent the juvenile from reentering the JJS after successful treatment for AOD abuse and release from court-ordered sanctions, continuing care (also referred to as aftercare) must be a strong component of any treatment program for diverted juveniles. Effective continuing-care programs will increase the likelihood that youths will remain AOD-free and will not return to the juvenile court on new charges. An effective continuing-care program should

- Support sobriety by emphasizing relapse prevention and recovery planning
- Facilitate effective reintegration into the community and positive activities
- Facilitate and ensure continuity and application of competencies gained during treatment
- Reduce recidivism among offenders released from residential facilities
- Decrease the number of juveniles who build lengthy delinquent careers and move on into criminal careers as adults (Altshuler and Armstrong, 1990).

The case manager should make clear that, should they need further treatment, the juveniles who have been in AOD abuse treatment because of illegal behavior may seek treatment directly and need not wait until they are referred to treatment through the JJS. The agencies participating in the management of the juvenile's case should agree upon the actions that each will take should

any recurring or additional problems occur at any time during AOD abuse treatment, continuing care, or followup.

Closure of diversion occurs whenever the juvenile completes the AOD abuse treatment plan that was implemented by court services or that was court ordered. The discharge plan, like the assessment and treatment plans, should be multidisciplinary and should be based at least in part on input from the youth and his or her family. Many jurisdictions have found graduation ceremonies or some other formal acknowledgment to have positive effects in increasing the juvenile's self-esteem and reducing the risk of relapse.

Relapse Prevention

Relapse episodes are to be expected during treatment and recovery. All involved parties, particularly case managers, must have some training in the prevention of relapse in adolescents. Relapse should not be seen as synonymous with failure. Although relapse is no longer perceived as a totally negative event but rather as part of the recovery process, the AOD-abusing juvenile should understand that even one lapse will have immediate consequences.

Zero tolerance of AOD use must be the officially stated policy in any system supporting AOD abuse treatment, but the consequences for failure should be somewhat flexible. If the juvenile is clearly making some effort and is progressing, the consequences may be minimal; however, a continuum of consequences, depending on the individual circumstances of the juvenile, may exist. For example, the juvenile may face loss of privileges (earlier curfew, increased community service hours, more frequent urine drug screens, or weekend detention). Whatever the consequences, they must be clearly articulated, accepted by both the JJS and AOD abuse treatment systems, explained when juveniles enter the program, and applied consistently.

Public Health System Goals

Typically, juveniles involved in the JJS are medically underserved. They often come from families that cannot afford primary healthcare or are unable to gain access to the available healthcare system, or whose lifestyle does not support participation in ongoing treatment. The medical

profession must mobilize to assess the needs of and provide services to juveniles who have committed AOD-related offenses. This is the first step toward ensuring access to healthcare and preventive services and toward ensuring a continuity of care for medically underserved juveniles. Medical intervention will benefit the individual youth and the public health interest as well. The public health system's goals include case-finding, disease prevention, and health promotion.

It is essential to mobilize the medical profession to join the effort to assess and provide services to meet the healthcare needs of juveniles involved in AOD-related offenses.

Medical Assessment

The purpose of medical assessment is threefold: 1) to identify acute illnesses or chronic medical conditions, 2) to identify communicable diseases, and 3) to identify health-compromising risk factors. Obtaining a detailed medical and behavioral history, focusing on common problems found in adolescence, followed by a complete physical examination and appropriate screening tests, will contribute to an effective intervention plan for the individual youth. Providing an extensive listing of medical problems and methods of assessment is beyond the scope of this document; interested readers are referred to textbooks on adolescent medicine.

Common or often unrecognized medical problems among youth at risk include asymptomatic communicable diseases that may result in late complications in the individual; these diseases include hepatitis, tuberculosis, and sexually transmitted diseases (STDs) such as gonorrhea, chlamydia infection, syphilis, trichomoniasis, or HIV. Chronic medical problems may be accompanied by no symptoms or mild or intermittent symptoms, yet associated with grave consequences if left untreated. These problems include hypertension, seizure disorders, reactive airway diseases, diabetes, nutritional deficiency, rheumatic carditis, or conditions related to inadequately treated injury, such as chronic osteomyelitis.

Nutritional deficiency in adolescents may stem from poor dietary intake, eating disorders, AOD abuse, or chronic illness. Every AOD abuse treatment program must develop a system for

referring patients to such community-based health services as health maintenance, immunization, continued care of chronic medical conditions, and other basic services.

More than 70 percent of boys and more than 50 percent of girls in the United States become sexually active by the 12th grade. Youth involved in the JJS, as well as AOD abusers, tend to engage in high-risk sexual activities such as not using condoms, having multiple at-risk sex partners, or engaging in sexual activity while under the influence of AODs. Screening for and management of high-risk sexual activity, STDs and HIV infection, and pregnancy are some of the priority areas in medical assessment of these youth. Chlamydia and gonorrhea infections (urethritis or cervicitis) are among the most common STDs in both male and female adolescents. Syphilis and hepatitis rates are also higher among AOD-using adolescents and young adults than among those not using AODs. Although infectious, a majority of STDs are asymptomatic and therefore remain undiagnosed and untreated until late complications occur—unless a screening program is in place.

Screening for treatable STDs should result in an assessment of behavioral risk, treatment of juveniles who test positive and of their sex partners, and education to reduce the risk of reinfection. Consequences of untreated or unrecognized lower genital tract infections are much greater for girls than for boys. Complications of untreated STDs in girls can include infertility, ectopic pregnancy, pelvic inflammatory disease, and transmission of the disease to their babies in utero or intranatally. Risk assessment and screening for sexually transmissible viral infection, particularly HIV, is desirable and should be offered with assurance of confidentiality, appropriate counseling, and referral resources. The screening and management of STDs and HIV infection among populations at high risk of exposure, such as AOD-using juveniles, have significant public health implications as well. However, screening for HIV infection in the absence of strict confidentiality and appropriate counseling is not advisable.

Patients who are pregnant must receive medical attention and supervision, and preventive/early screening for gynecologic healthcare problems. Early referral of pregnant AOD users to prenatal care is especially critical.

Provision of Health Information and Education

Most juveniles lack critical information about risk reduction, immunization (because they have never had primary preventive care), pregnancy and family planning, steroid use, nutrition, and eating disorders. Staff members of diversion programs need this information not only to educate the juveniles in their care, but also to reinforce prevention efforts, make appropriate referrals, use appropriate precautions to minimize their own risk of exposure to disease, and help prevent juveniles in need of treatment from being excluded on the basis of their ignorance or misperceptions regarding medical conditions. Thus, staff training is a critical component of any educational effort.

Adolescent illness and death are largely preventable, and when they do occur, they are usually attributable to intentional or unintentional injury or high-risk behavior. Prevention through health education, including abstinence, and the promotion of healthy lifestyle must be goals of the public health system. Reproductive health education, including abstinence and family planning for both female and male adolescents, prevention of STD/HIV infection, and promotion of physical fitness must be integrated into all diversion programs for juveniles.

The preventive training may be delivered in group sessions or in individual sessions using curriculums that are developmentally appropriate for youth. The effectiveness of education programs may be enhanced by involvement of peer counselors and implementation of programs that are sensitive to the gender and cultural needs of the target youth.

Violence-Related Injury Prevention

Violence is one of the leading causes of death among adolescents and young adults in the United States, and it is the number one cause of mortality among male youth living in some urban areas of the United States. AOD-abusing youth in the JJS often are the victims of child abuse or neglect, or they are witnesses to domestic violence. Studies have shown that violence is a learned behavior. Primary prevention and early intervention are critical if this deadly public health problem is to be controlled. When assessment reveals that the juvenile has a history of

exposure to violence as a victim or bystander, or has a propensity for violent behaviors, assessment should be followed by intervention in the form of appropriately focused therapy or participation in violence prevention programs. These interventions must be available to all youth in the diversion programs. A long-term, sustained intervention may be necessary for success in violence prevention.

The staff of AOD abuse treatment diversion programs should be knowledgeable about the origins of violence, interpersonal conflict resolution skills, and nonviolent anger management. Participation in a violence prevention and conflict resolution workshop is desirable for training staff in the JJS and in the diversion programs because a propensity for violent behavior is common among AOD-abusing juveniles.

Mental Health

Many juveniles have coexisting AOD and mental health problems, such as posttraumatic stress disorder, depression, bipolar disorder, or schizophrenia. Many mental disorders have such a direct and significant impact on a juvenile's behavior or ability to perform daily cognitive tasks that AOD abuse treatment would be ineffective without concurrent mental health treatment. Early assessment, diagnosis, and treatment of both AOD abuse and coexisting mental health problems are necessary for diversion to be successful.

The collaboration should develop linkages and establish a process to meet both the AOD abuse and the mental health needs of the juveniles in its community. Many AOD abuse treatment programs are part of a larger community mental health center, so this tandem treatment process should not be overly difficult to achieve. Where the two treatment systems are separated, turf issues—such as professional versus paraprofessional credentials, who "owns" the youth, or whether psychiatry addresses AOD issues properly -- must be resolved before agreement can be reached.

The strengths of both systems should be the basis for the linkage. Both treatment systems share the youth- and family-centered view. AOD abuse treatment has long sought to place the

recovery process with the client. Community mental health centers have great expertise with emergency situations such as suicide attempts, and many have extensive "wraparound" services that would further support a youth in treatment. Some of the services are therapeutic foster care, in-home therapy, sexual abuse recovery programs, outreach, and medication management. Both treatment systems should share the goal of developing a single comprehensive treatment plan. *The burden of coordination should be on the providers, not on the youth or the family.*

Conclusion

This chapter has addressed the basic goals of AOD abuse treatment diversion programs for youth involved in the JJS. Specifically, it has attempted to address the goals of the four human service systems that will be most likely to participate in a consortium program to divert youth safely from the JJS to AOD abuse treatment. The four systems are the JJS, the AOD abuse treatment system, social services, and the physical and mental health systems in the community. In addition to providing information about the specific systems, the discussion has illustrated the common ground shared by these systems with respect to youth with AOD abuse problems.

The next chapter provides guidelines for planning a collaborative approach to an AOD abuse treatment diversion program. The key to a collaborative approach is to effectively divert youth with substance abuse problems from further penetration into the JJS and into AOD abuse treatment. This type of collaboration will allow youth to receive the "best of both worlds." They receive treatment for their AOD abuse problems with the full support and authority of the juvenile court.

TIP 21: Chapter 3—Collaborating on a Diversion Program

Planning and implementing an alcohol and other drug (AOD) abuse treatment diversion program is not a simple task. Many issues must be considered before comprehensive planning for a

system to divert youth from the juvenile court system to appropriate AOD abuse treatment can begin. Complex decisions must be made by a collaborative group that is formed to plan and to get the program started. Collaborators will be most effective if they agree to use a consensus-building decisionmaking process. This process encourages dialogue, and members will have to find common ground upon which they can agree. Consensus builds ownership and does not require absolute agreement on every point.



Exhibit 3-1 The Systems View of Collaboration (more...)

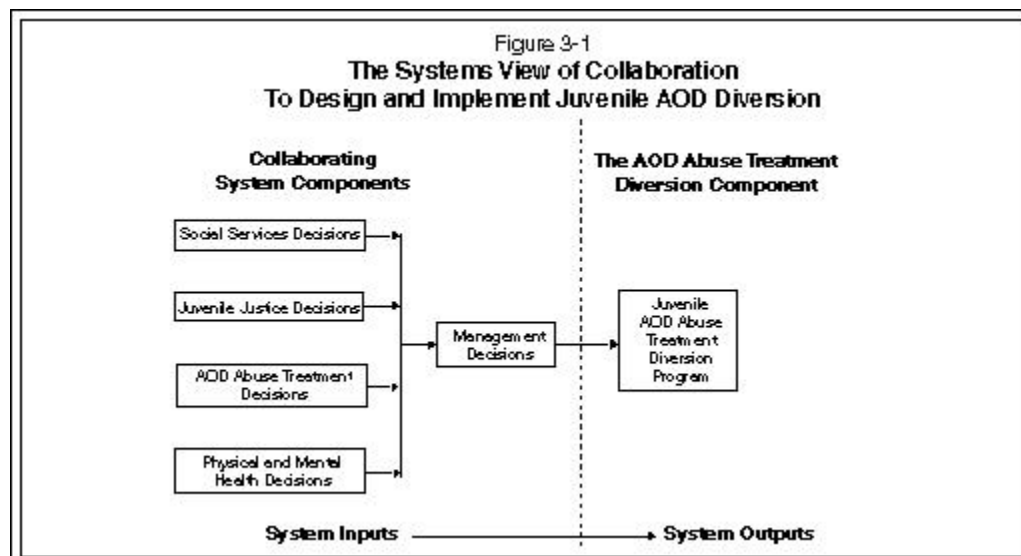
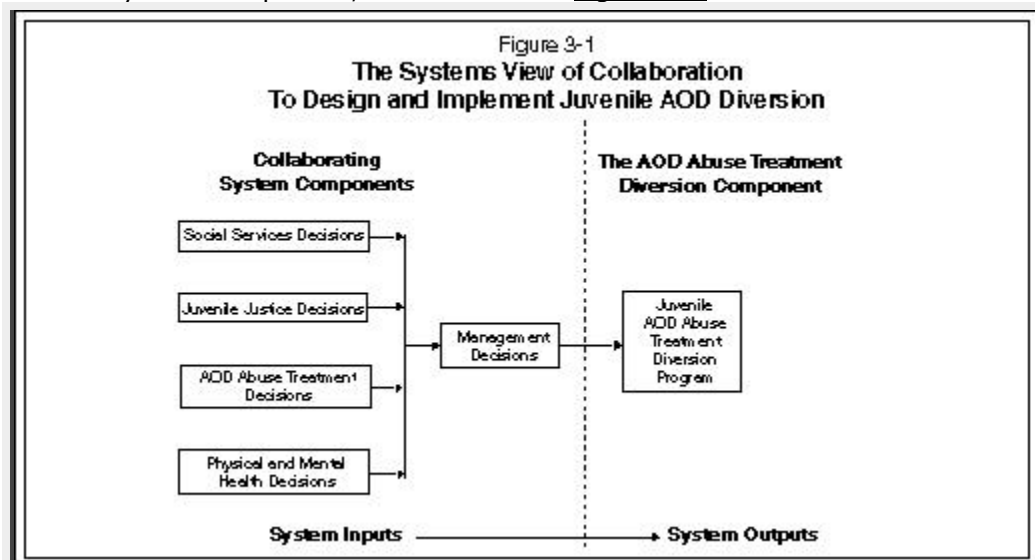


Exhibit 3-1 The Systems View of Collaboration To Design and Implement Juvenile AOD Diversion

The decisions can be made most effectively if members of the collaborative planning committee take a simple systems view of the development process and the diversion program being designed. For planning purposes, the juvenile justice system (JJS), AOD abuse treatment,

physical and mental health services, and social services should be considered essential system components that together with other community collaborators, such as the education system, make up the juvenile AOD diversion program. Each system component is a partner in the planning and implementation process. The collaborators must be sure that the purposes and needs of each system are considered as they design a diversion program. Likewise, they need to put into place an effective management system. This management system can be considered another system component, as illustrated in [Figure 3-1](#)



The Functions of the Collaborating Committee

The collaborating committee will deal with wide-ranging issues. For example, after the creation of the committee, one of the most critical steps is for its members to reach consensus on the definition of diversion. This definition forms the basic construct of the system under design, and it sets the stage for consideration of issues that range from the identification of juvenile offenders appropriate for treatment and what types of treatment shall be available to them, on the one hand, to the identification of funding sources on the other.

The collaboration is most likely to be effective if the participants agree to use a consensus-building decisionmaking process. This process encourages dialogue, and participants will have to find enough common ground on which to agree. Consensus builds ownership.

Five major types of decisions confront the collaborating committee:

- Juvenile justice decisions
- AOD abuse treatment decisions
- Physical and mental health decisions
- Social services decisions
- Management system decisions.

While some of the core decisions within each system can be made only by members of that system, collaborators from the other groups may be involved in decisionmaking by becoming informed, raising questions, and then working toward the goal of building a unified system that will continue to receive input from the major system components.

The many decisions to be made by the committee are reviewed in this chapter, which has been written to help collaborators prepare for the work they will perform.

Identifying the Stakeholders To Be Involved in the Planning Process

Ideally, every community will recognize and acknowledge that AOD abuse presents a challenge that must be confronted for the best interests of its children and families. The planning effort must be guided by people who accept this premise.

People from all strata of the organizational hierarchy of the JJS and local officials should be included on the planning team, including court services staff, supervisors, administrators, community volunteers, physicians, AOD abuse treatment and community health providers and agencies, and local officials or their designees. The team must include decisionmakers who have knowledge of the juvenile justice and AOD abuse treatment issues involved.

When planning an AOD abuse treatment diversion program or system, it is necessary to have two types of people as members: 1) those who understand and have an interest in the broad and specific problems of community welfare, juvenile justice, AOD abuse, and health and social

services and 2) community leaders who can ensure that productive change occurs. They may represent public, private, or business and industrial organizations, or they may be community volunteers.

Community Decisions

- Identifying the stakeholders and leaders to be involved in the planning process
- Agreeing on community accountability
- Planning for the presence of urban, suburban, and rural differences
- Defining the roles and expectations of families
- Planning the focus and influences of community diversity

JJS Decisions

- Developing the diversion concept
- Identifying the points in the justice process at which diversion can occur
- Devising effective education and training programs for judges and court services personnel so that they know and understand the treatment resources available, and so that the most effective treatment approach can be implemented for each juvenile
- Helping treatment providers and public health officials understand the JJS
- Establishing procedures for judicial responses to AOD abuse treatment issues
- Defining appropriate target populations within the JJS's jurisdiction
- Defining noncompliance and completion of AOD abuse treatment
- Identifying the types of information required to measure outcomes needed for decisionmaking
- Developing the ability to supervise AOD-abusing juvenile offenders and monitor treatment progress

While some of the core decisions within each system can be made only by members of that system, collaborators from the other groups can be involved in decisionmaking by becoming informed, raising questions, and then working toward the goal of building a unified system.

AOD Abuse Treatment Decisions

- Defining the needed continuum of services
- Identifying needed treatment modalities
- Defining treatment expectations
- Defining and locating services
- Establishing uniform eligibility and acceptance criteria
- Developing a screening and assessment process for placement in AOD abuse treatment
- Defining the supervision roles of AOD abuse treatment providers
- Planning to deal with issues of culture, gender, and ethnicity

Ethical and Legal Decisions

- Deciding what information is appropriate to exchange
- Deciding who is appropriate to receive information
- Protecting confidential electronic data
- Reporting in accordance with local, State, and Federal guidelines
- Defining the scope of confidentiality rules

Decisions Regarding Physical and Mental Health Services and Social Services

- Defining what physical and mental health services and social services need to be available to youth and families
- Establishing linkages with the AOD abuse treatment system to integrate services for youth into the diversion program

Management Decisions

- Resolving funding and cost considerations

- Ensuring confidentiality and adequate communication among all parties
- Identifying program management capabilities
- Encouraging interagency cooperation and collaboration (which includes written documentation)
- Developing preimplementation training and public education
- Conducting system oversight
- Defining the evaluation process
- Conducting feedback analysis and reporting on outcomes
- Defining the need for ongoing research
- Defining ongoing data and demographic requirements

Since funding is a critical issue, it is important to include in the first group people who are knowledgeable of funding streams, who are potential funders, or who have ties to funding organizations. Often, commitment to productive change is more important than a person's position or field of work. Planners from these groups are not likely to be directly involved in the implementation of the program, although some collaborating groups may designate some to be involved. Elected officials should be included on the collaborating committee if possible or appropriate. Often the single State agency (SSA) has the power to reprioritize funds based on identified local need.

The responsibilities of planning team members and possibly the team's composition may shift as planning progresses. For example, planning will require the participation of people with the ability to communicate problems and solutions, and it will necessitate support and commitment from people representing a variety of organizations in the community. Some members should be able to clearly explain the process of juvenile diversion and what it means for the JJS, the AOD abuse treatment field, and the community. As planning moves toward implementation, the judge and agency and department heads will need to assert leadership so that the program being planned can be activated. As planning moves to implementation and expands into ongoing programming, this committee leadership can be vital to sustaining the diversion program.

Each community that is planning a diversion program for AOD-abusing youth should evaluate the extent and nature of its AOD problems and develop a response that reflects the local challenges of AOD use and the unique characteristics of the community. Accordingly, the planning team membership should also reflect the community's social characteristics.

Because an evaluation plan is critical to developing the diversion program, members of the team should include people with appropriate research or project evaluation backgrounds. If this expertise is missing within the community, linkage with a college or university may be appropriate. The committee should take advantage of research findings and plan to document its efforts for future evaluation, feedback, and development. Selection of an individual with the ability to develop and operate a management information system (MIS) is necessary to ensure that appropriate data collection systems are in place.

Often, commitment to productive change is more important than a person's position or field of work.

Representatives of the Collaborating Groups

The specific members of each system component will vary from community to community. The representative membership of a hypothetical collaborating group might include individuals from the following groups.

Representing the JJS

- **Juvenile courts:** This group should include the juvenile court judge or the referee, master, or designee, as well as probation and parole officers and other representatives of juvenile court.
- **Prosecutors:** Some prosecutors are accustomed to working with a more limited concept of diversion than the definition proposed in this TIP. Involving them in the planning process can avoid any constraint on buy-in.

- **Public Defender's Office:** Included with representatives from the public defender's office may be those attorneys identified by or contracted with the jurisdiction to represent delinquent or status-offending youth.
- **Law enforcement:** Although official involvement with juveniles usually ends once the juvenile has been charged, police can serve as valuable mentors or community resources. Police also may want feedback about case disposition, particularly in community policing models. Some communities incorporate police officers into school systems as resource officers, an interactive arrangement in which police build trust with children and youth.

Representing AOD Abuse Treatment Providers

- **Youth AOD abuse treatment providers:** Include both public and private providers that specialize in adolescent AOD abuse treatment.
- **Community-based resources relevant to treatment:** In some parts of the country, continuing care and relapse prevention may be provided by physical and mental health services, social services, or other organizations.

Representing Physical and Mental Health and Social Services Providers

- **Community school professionals:** This group can include staff from the mainstream public and private schools as well as from alternative education environments. If the number of schools is too large to incorporate, a member from a representative teachers' organization may be selected.
- **Healthcare professionals:** These professionals may be private practitioners or representatives of public and private providers, as well as providers focusing on prevention or representatives of professional organizations such as the National Association of Social Workers. They should include representatives from community mental health centers

(most States have a well-developed network of community mental health centers or child guidance programs) and from the public health department. The public health system ensures that general medical services (preventive health care, infectious disease screening and treatment, and reproductive healthcare) are incorporated as appropriate in treatment programs.

- **Social services professionals:** This group can include professionals from public and private social welfare agencies, child protective services, child welfare organizations, and family service programs (for example, the Salvation Army, Jewish community services, and city and county human services organizations).

Representing the Community

- **Support groups:** This category includes such groups such as Alcoholic Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery (RR). If AA, NA, and RR have no meetings for youth, perhaps adult members can participate in the implementation effort by initiating them. Since AA, NA, and RR have no official representatives, participants from these groups will be active, interested private individuals with a special interest in assisting youth.
- **Victim advocacy groups:** These groups have different names in different localities but will be known to most professionals in child and juvenile welfare organizations.
- **Business community:** Members of the business community who are involved in decisions about healthcare coverage and who also have an interest in youth as future members of the workforce should be included. Planning committee members from businesses can provide assistance by establishing youth advocacy efforts, offering incentives such as job training and other opportunities for recovering youth, supporting drug

testing as a condition of employment, and making facilities available for use as meeting space by the planning committee.

- **Parent groups:** Parents who have experience with juvenile justice and AOD abuse treatment should be included but not parents whose children are currently in these systems.
- **Teenage peers:** Youth recovering from AOD abuse problems should be included.
- **Clergy:** Clergy and members of the religious community have the resources and ability to make decisions that have a positive impact. They may offer cultural or ethnic perspectives on the diversion program, as well as support the program. They also can educate their congregations about the AOD abuse treatment diversion program.
- **Community elders:** Elders who can provide guidance and practical perspectives often are available to volunteer. Diversion is not a new concept, and many times the community elders have particularly salient views on why past efforts have succeeded or failed.
- **Funders:** Representatives of both private and public funding sources should be included, as well as lawmakers who develop legislation for programs and who are responsible for the appropriation of funds.
- **Local officials:** Representatives from the mayor's office, the city council, the county board, and local representatives to the legislature should be included.
- **Volunteer organizations:** Examples include community youth service organizations such as Boys and Girls Clubs, Big Brothers/Big Sisters, YMCAs and YWCAs, police youth clubs, service sororities and fraternities, Civitan clubs, and other youth organizations such as church groups or entrepreneurship development programs.

The length of this list suggests that a large group might be created, so large that it could outnumber the target population of AOD-abusing youth. In a large city, the collaborating group

might be even larger. It is more likely, however, that a much smaller group would participate with representatives from a few key organizations interested in juvenile welfare and community safety.

The following chapter describes some of the major decision points facing the collaborating committee. They are provided to assist local groups in planning and developing their AOD abuse treatment diversion program for appropriate juveniles involved in the JJS.

TIP 21: Chapter 4—Planning Juvenile Diversion to AOD Abuse Treatment

There is no single formula for planning a program to divert juveniles to alcohol and other drug (AOD) abuse treatment, but the consensus panel developing this Treatment Improvement Protocol (TIP) recognized that community focus is crucial. This focus will differ, however, from one community to another, depending on local problems, community perceptions of those problems, and the goals and objectives defined by the collaborating committee.

Regardless, the community is the key to the development and maintenance of a program to divert juveniles to AOD abuse treatment that will benefit them in time.

An individual or group of individuals will provide the initial impetus for the planning process, and it will be defined initially by their goals and objectives for juvenile diversion to AOD abuse treatment. As more individuals and groups become involved, the collaborative process will take on its own character.

This chapter is intended to help local collaborators get started and make the decisions that will define the diversion program. Whatever the makeup or the procedures of the collaborating committee, required decisions fall into the areas outlined in [Chapter 3](#). Collaborators on the planning committee should develop a system composed of the community, the juvenile justice system (JJS), AOD abuse treatment services, and physical and mental health and social services,

as well as a strong management component. Viewing the planning process this way can help collaborators to organize it.

Typical decisions that must be made by collaborators are the subject of this chapter. It is important to remember that the key decisionmakers for any particular set of decisions will be the representatives of the component most directly involved. But the combined thinking of representatives of all the components is required. That is why the consensus panel emphasized the term "collaborative" in defining the planning process.

The community is the key to the development and maintenance of a program to divert juveniles to AOD abuse treatment that will benefit them in time.

Community Decisions

Community Accountability

The consensus panel felt strongly that communities must work to develop their own solutions to address juvenile AOD and delinquency problems. They should accept and acknowledge the fact that these problems must be treated locally, and they should conduct needs assessments to determine whether they have sufficient AOD abuse treatment resources to do so.

There has been extensive research on the antecedents of both delinquency and the early use of AODs. In *Recidivism Among High-Risk Youths: Study of a Cohort of Juvenile Detainees*, Dembo and associates write that Youths whose behavior in the community has brought them into contact with the legal system often are experiencing multiple problems. These problems include drug use, histories of physical abuse and sexual victimization, and other emotional and psychological functioning difficulties. . . . Particular attention has been focused on the association between child maltreatment and delinquent behavior. . . . Children's physical and sexual abuse experiences are associated with illicit drug use and other delinquent behavior.

Chaiken and Johnson wrote about adolescent AOD abuse in 1988: The primary factors that promote use are the general availability of alcohol or drugs, friends who are users, lack of

parental supervision, and lack of attachment to school. The involvement of adolescent users in other destructive behavior is strongly associated with the number and types of harmful substances they use. . . . Youngsters who use multiple drugs are generally more likely to be seriously delinquent than those who use only alcohol or marijuana. . . . Those who use drugs -- even only alcohol or marijuana -- are more likely to smoke, be sexually active, and ride around in cars with drivers either drunk or on drugs. Over 75 percent of boys who use alcohol and marijuana commit minor assaults, vandalism, or other public disorder offenses. Both boys and girls who drink and use marijuana or other drugs are more likely to be truant and to steal. . . . The few studies that have followed delinquent youngsters into adulthood have shown that, in general, youngsters are most likely to continue to be offenders as adults if

- They come from poor families
- They have other criminals in their families
- They do poorly in school
- They started using drugs and committing other delinquent antisocial acts at an early age
- They used multiple types of drugs and committed crimes frequently
- They have few opportunities in late adolescence to participate in legitimate and rewarding activities.

Communities must recognize which risk factors have an impact on their youth and families and must develop resources to fill the gaps in the continuum of care and other service systems.

Communities also need to address cultural foci and influences that will affect programming. For a diversion program to achieve long-term success, it must be part of the natural care network of the community, which develops and supports healthy, successful, sober youth. This network can include church programs, after-school programs, recreation center programs, tutoring services, mentoring programs, and volunteer efforts.

Communities need to develop resources to fill the gaps in the continuum of care and other service systems.

Local Differences and System Development

Urban, suburban, and rural differences can present different challenges in determining how an AOD abuse treatment diversion program is developed. Issues for consideration include 1) access to transportation, 2) the accessibility of services (including the increased burden on families if services are not available locally), 3) availability of services, 4) drugs of choice, 5) special community needs, and 6) level of community acceptance of the problem.

Transportation to treatment services can be a problem anywhere. In rural areas without public transportation, treatment services may be at too great a distance from clients' homes. In urban areas, even youth with access to mass transit may not have the bus fare they need to travel to treatment. Budget problems are forcing many cities to curtail public transportation services. Residents of poor neighborhoods often feel these curtailments more deeply than others. Parental involvement is an important key to solving transportation and accessibility problems. Offering treatment services in or near a school may decrease transportation problems, as may the availability of mobile clinics (some rural outreach programs use a motor home) or in-home services. AOD use patterns vary somewhat from community to community and from region to region. Certain drugs are more available in some communities than others. Drug trafficking may be more visible in some urban settings, where it is often conducted openly on street corners. Smaller markets and more private settings make this high visibility less common in rural areas and in the suburbs. Many agricultural communities are aware that some of their production is devoted to marijuana.

Juveniles will use what is accessible and affordable. Their level of sophistication is another factor in influencing which drugs they will use. Each community will need to survey trends of AOD use among its youth and families.

In developing diversion programs, communities must seek strategies that address their particular needs and the specific issues they face. System development issues may differ according to the urban, suburban, or rural nature of the community. For example, in some areas, the planning committee may focus on keeping diverted juveniles in school. The youth in AOD

abuse treatment may be amenable to treatment in an outpatient setting while continuing to attend school. In other areas, however, an early goal may be to remove the child from the community (including the school) where drugs are a pervasive influence.

JJS Decisions

When a case is referred to juvenile court, the court decides whether to process the case formally and file a petition (prosecute) or to handle the case informally without a court hearing. Diversion to AOD abuse treatment may occur at any point along the JJS continuum from juvenile court intake, when it may be part of informal adjustment or a preadjudication agreement, to postadjudication, when it may mean probation or placement in a community treatment facility rather than in a training school or other similar institution. *It is important to remember that the juvenile is not removed from the JJS; rather, diversion exists as an alternative approach to accountability, focusing on the juvenile's need for AOD abuse treatment.*

Successful completion of the AOD abuse treatment ordered may change the accountability demands on the juvenile. Sanctions should be proportionate to the degree of harm resulting from the underlying offenses. The juvenile may be discharged from court supervision, or in other cases, diversion to AOD abuse treatment may be only one part of a broader accountability approach such as restitution or community service.

Exhibit 4-1 Points for Youth Diversion to AOD Abuse

(more...)

The responsibility of the courts to hold juveniles accountable is not negated by diversion; rather, the court's authority to mandate treatment for AOD use should be seen as a significant asset to the balanced approach in the rehabilitative process. A youth may be diverted into AOD abuse treatment at all the points shown in Exhibit 4-1, Points for Youth Diversion to AOD Abuse Treatment, from the point of referral to the court through disposition after adjudication.

Defining the Target Population for Inclusion

Planners must clearly define and state the appropriate target population for the AOD abuse treatment diversion program. The consensus panel defined the target population, for purposes of this TIP, as juveniles who come to the attention of the JJS from a variety of sources, including police referrals, parental referrals, and referrals from other community agencies, such as the schools. (Remember that the local planning committee's definition may differ from the one recommended by the Center for Substance Abuse Treatment (CSAT) consensus panel. What follows is the consensus panel's definition.)

A juvenile in the context of the JJS is a person who, by reason of age, falls under the jurisdiction of the court. Different States have different age ranges to determine juvenile court jurisdiction; however, it is common for a juvenile to be defined in the context of acts of delinquency as a youth who is older than 10 and younger than 18.

A *delinquent offender* is a juvenile who has committed an act, including a violation of State laws and local ordinances that would be a crime if committed by an adult. For example, if a juvenile is under the age of legal jurisdiction for an adult and commits a burglary, the juvenile has committed a delinquent offense and is subject to the jurisdiction of the juvenile court. A *status offender* is a juvenile who has committed an offense that would not be a crime if committed by an adult. Status offenses describe behavior by juveniles that society wants to control. For example, many communities institute curfews only for juveniles. *Preadjudicated delinquent offenders*, youth charged with a delinquent offense who have not yet been adjudicated as delinquents, may also be eligible for AOD abuse treatment diversion.

A juvenile in the context of the JJS is a person who, by reason of age, falls under the jurisdiction of the court.

Youth targeted for diversion from the juvenile court must first be eligible for jurisdiction by the court. Most systems have juvenile court intake procedures designed to establish the jurisdiction of youth referred to the court. Establishment of juvenile court jurisdiction usually depends upon

the following criteria: 1) determination that the alleged offense(s) occurred within the geographical boundaries of the court, 2) determination that the alleged offense(s) constitutes a delinquent or status offense as defined by law, and 3) determination that the youth referred meets the definition of delinquent or status offender.

A primary goal at intake. One of the primary goals of juvenile court intake is to investigate the circumstances surrounding the alleged offense(s) to determine whether court intervention is necessary. As a result, juvenile court intake should be a key decision point for establishing whether or not a juvenile will be diverted.

Courts must intervene early to increase the effectiveness of AOD abuse treatment. Therefore, any child within the JJS who has been identified as having an AOD problem may be considered eligible for diversion to AOD abuse treatment. An appropriate response to the offense is essential. A guideline for AOD abuse treatment diversion is to look for the youth for whom this type of intervention will be most effective, balancing against this benefit the need for appropriate sanctions and the need to maintain community safety. Specific target populations may include 1) status offenders, 2) youth who have been charged with delinquent acts but are not adjudicated delinquents, 3) those who have been adjudicated, and 4) juvenile offenders on probation who have violated the terms of their probation.

This population description should not be interpreted to mean that AOD abuse treatment diversion is the appropriate response for all juveniles or all criminal behavior in the JJS. Individualized justice is the legitimate goal of the JJS. Youth who are being waived to an adult court, for example, would not be candidates for AOD abuse treatment diversion. Youth who are charged with extremely serious offenses or those who have chronic patterns of delinquent behavior may be best suited for detainment in a secure residential facility or, in extreme cases, transferred to the adult system. Further, through the assessment process, specific youth may be returned to court without a recommendation for diversion (e.g., youth who have been through treatment or diversion previously). Diversion uses an individualized approach to respond to the AOD abuse of juveniles before the courts.

Status offenders. A substantial part of the population under consideration for AOD abuse treatment diversion is likely to consist of status offenders. All States have some type of status offense jurisdiction, but they may vary on different definitions of status offense, and even within a State, court jurisdictions may have different understandings of the term. This difference highlights the difficulty that is implicit in the process of bringing together two systems -- juvenile justice and AOD abuse treatment -- that may not always speak the same language. One system in two contiguous jurisdictions may not define behaviors in the same terms. AOD abuse treatment programs often serve clients in several jurisdictions.

Status offenses include truancy, running away from home, curfew violation, acting beyond the control of parents, and unruly behavior. Using tobacco and alcohol may be considered a status offense in some States. All States have laws that proscribe such behavior and place jurisdiction of status offenses in the juvenile courts.

While the juvenile court does not have the same power under Federal law to detain or incarcerate the status offender as it does with delinquents, status offenders with AOD problems may be best served in an AOD abuse treatment diversion program because they are at an appropriate age for diversion and may not yet pose a serious threat to the safety of the community. Status offenses are frequently "gateway" activities that may provide a useful net to catch youth who are at high risk of using AODs or becoming involved in more serious delinquent behavior. Usually, youth who commit status offenses can be diverted most successfully if they have access to a system to support their participation in the diversion program. These support systems can include the family, the school, and other community service providers.

A problem associated with diversion for status offenders is that the current understanding of status offense is that youth who have committed these offenses are beyond the scope of the JJS. The Juvenile Justice and Delinquency Prevention Act of 1974 required the separation of juveniles from adults during incarceration and removal of status offenders from secure detention and correctional facilities. In 1980, Congress amended the 1974 act to allow States to detain status offenders if detention occurred for the violation of a valid court order. Thus, it may be argued that there is little clout behind diversion for a status offender and not much enforcement capacity

if the youth tries to leave treatment. Nonetheless, even though it appears the juvenile court's powers are limited, some measures can be taken. The juvenile court does have a limited power to detain under the valid court order exception. Also, some States have the authority to take away a youth's driving license for a status offense; other States can put responsibility on the parents through court order and require the youth to participate in the treatment process, with contempt options and fines as the consequences for parental noncompliance. Public sentiment is moving increasingly toward demanding accountability from parents for the actions of their children and diversion for status offenders.

Preadjudicated delinquent offenders. Preadjudicated delinquent offenders with AOD abuse problems may also be eligible for AOD abuse treatment diversion. Many cases are resolved at intake with juvenile court interventions, so this category includes youth charged with a delinquent offense who have not yet been adjudicated as delinquents. The juvenile may be within the jurisdiction of the court by referral, complaint, or affidavit, or may have been formally charged by petition. At either point, the youth may be referred to diversion. Successful completion of the diversion program may result in the dismissal of all charges. Expungement of the case record may also be a reward for successful completion. If the juvenile does not comply with diversion conditions, the juvenile court may reinstate the charging document or schedule or resume the formal adjudication of the case and impose appropriate dispositional sanctions.

Adjudicated youth. Youth who have been adjudicated as delinquents by the juvenile court may also be candidates for diversion into an AOD abuse treatment program instead of receiving formal dispositional sanctions. Even those who have been adjudicated and received formal dispositional sanctions other than AOD abuse treatment diversion and then have broken the conditions of their court-ordered sanctions may be eligible for referral to AOD abuse treatment rather than placement in a juvenile correctional institution or other secured setting.

Violators of probation. Probation violators are juveniles who have been adjudicated and have received probation as a formal dispositional sanction, who have not been diverted to AOD abuse treatment, and who have broken the conditions of their probation. If the probation violation is

AOD-related, it is possible that these juveniles will be candidates for referral to AOD abuse treatment rather than placement in a juvenile correctional institution or other secured setting.

Status offenses include truancy, running away from home, curfew violation, acting beyond the control of parents, and unruly behavior, acts that would not be considered criminal if committed by an adult.

Categories of Offenders for Inclusion

It is important to consider carefully certain categories of delinquent offenders when determining eligibility for diversion from traditional juvenile court sanctions to AOD abuse treatment.

Specifically, AOD abuse treatment diversion criteria for violent offenders, arsonists, and sex offenders must be established.

Youth who commit violent offenses. The issue of violence is often pivotal in determining eligibility for diversion programs. A history of violence should not automatically exclude a youth from consideration for diversion into AOD abuse treatment. All youth should be considered for diversion on a case-by-case basis.

Many AOD abuse treatment programs have eligibility criteria that exclude violent offenders; the assumption is that these offenders will receive AOD abuse treatment through appropriate sanctions within the JJS and not through diversion. While categorical exclusion of violent youth from diversion to treatment may seem logical, the consensus panel recommends that exclusion or inclusion be considered on a case-by-case basis and that a youth's propensity for violence should be just one eligibility criterion, although a crucial one. As an approach that might balance and simultaneously address community protection, juvenile accountability, competency development, and individualized assessment and treatment, threshold questions can be posed before making this decision; for example, the following questions may be asked:

- Does the youth under consideration have a history of violent behavior, or has he or she committed a single violent act?
- What type of violent act did the youth commit?

- Is the youth with a history of violent behavior amenable to treatment?
- Does this youth pose a serious threat to the safety of the AOD abuse treatment staff or to participants?
- To what degree is the youth's violent behavior linked to AOD use?
- Is AOD diversion a consistent and appropriate sanction for the violent behavior?

It is important to consider the meaning of violence and the impact a violent offender might have on an AOD abuse treatment program. Generally, violence can be considered to be behavior that results in serious injury to oneself or others. Threatening or attempting to cause serious personal injury is also usually considered a form of violent behavior. Conversely, pushing, shoving, and fighting, which are common behaviors in the sometimes volatile population of juvenile AOD users under consideration in this TIP, are not necessarily violent behaviors with the same impact.

Therefore, in considering violence, it is necessary to look not just at specific acts and chargeable offenses but also at patterns of behavior that show a history of violence and that may be symptomatic of mental or emotional disorders that are diagnosable according to the *Diagnostic and Statistical Manual*, fourth edition (DSM-IV), the publication of the American Psychiatric Association that defines mental and emotional disorders. It is necessary to examine not just the youth's action but also the context of his or her actions and to learn as much as is known about the youth's life and psychological profile. The importance of individualization is critical in program matching.

Youth who set fires. Youth with histories of arson also pose special problems. They can be divided into at least three categories: 1) youth who commit arson for gain, on a dare, as part of a gang initiation, or for some similar motivation; 2) youth with an inner compulsion to set fires; and 3) youth with a long arson history that is related to physical or sexual abuse. (For more information, refer to the DSM-IV.)

All youth with a history of setting fires can pose a danger in treatment programs, especially residential programs, where they may place other residents and staff of the facility in danger.

Their histories should be thoroughly assessed to identify their problems and determine their treatment needs and to ascertain how threatening they may be to others in the treatment program. Youth with a tendency to set fires may think that the quickest way to get out of treatment is to set a fire, and that potential motivation should be taken into consideration. These youth may be treatable, but their potential impact on a treatment program must also be a factor in diversion and placement decisions. All such cases must be considered on an individual basis.

Pushing, shoving, and fighting, which are common behaviors in the sometimes volatile population of juvenile AOD abusers under consideration in this TIP, are not necessarily violent behaviors.

Youth who commit sex offenses. Sex offenses are another form of violent behavior requiring special consideration. It is important to look at the nature of the sex offense before making a decision about disposition or diversion. For example, a youth charged with voyeurism is not necessarily a violent sex offender and may well be a good candidate for diversion to AOD abuse treatment; however, the presence and impact of voyeuristic behavior should not be minimized. In most jurisdictions, prosecutors have a great deal of discretion in deciding how these cases will be filed, and diversion should not be ruled out automatically just because the label of sex offender has been applied. A sex offender evaluation can assist the treatment provider in determining risk and appropriateness for diversion.

It should be noted that violent behavior or a history of setting fires or committing sex offenses is likely to decrease the youth's potential for diversion. Many AOD abuse treatment programs may not have the necessary clinical supports or facility design to serve all youth. Often the best course of treatment for these juveniles may be to incorporate AOD abuse treatment into programs that are specifically designed to treat these identified behavioral problems.

Defining Noncompliance and Completion of Treatment

While a juvenile offender's diversion to AOD abuse treatment is an active engagement to address substance abuse, the development of understandings regarding noncompliance is equally

important. The JJS has a responsibility to ensure that juvenile offenders are held accountable for their actions. In developing a protocol for noncompliance with the diversion program, planners should consider clear definitions of accountability for noncompliance. Examples of noncompliance include absconding from the program, a positive urine drug screen, commission of other delinquent acts, lack of participation in the treatment process, and failure to comply with the individualized diversion contract. From the defined behaviors, the ground rules for noncompliance should be established -- rules that cover issues such as reporting mechanisms; who reports the noncompliance, to whom, when, and how (for example, written messages or a phone call can be documented), and a set of sanctions for each type of noncompliance.

Examples of the accountability-based sanctions of noncompliance will differ depending on the point in the JJS where the diversion has occurred. Consequences should range from one-time events to significant changes in the youth's status. Possible sanctions include termination of the diversion contract, referral by petition to the JJS for adjudication, revival of suspended proceedings, or transfer to intensive supervision, detention, or a correctional institution. Accountability-based sanctions should be commensurate with the degree of noncompliance. The goal of such sanctions should be reparative or restorative. Sobriety may be a result of the reparative process. Further, accountability-based sanctions should be proportionate to the degree of harm resulting from the noncompliance.

Similar guidelines can be applied to completion of AOD abuse treatment. What is meant by completion of treatment should be clearly defined in cooperative agreements and individualized diversion contracts. Treatment completion should be defined by the achievement of specific behavioral markers rather than by the length of stay or an arbitrary number of clean drug screens. Just as there are consequences for noncompliance, the diversion agreement or court order should also provide for early rewards commensurate with early progress in treatment.

The contract can state program expectations and goals. For example, stated expectations might be that the juvenile

- Actively engages in a positive manner on problems identified in the treatment plan and personal goal sheet
- Demonstrates positive skills in school, home, community, and treatment
- Continues to work on relapse prevention and recovery plan
- Has long-term educational and vocational plan.

Benchmarks indicating that the youth has met diversion program goals and expectations might include when he or she

- Resolves conflicts with family in positive manner
- Readily accepts full responsibility for offending behavior and decisions
- Maintains positive behavior and progress in school or work, home, and the community
- Actively works toward personal goals
- Can resist negative peer pressure in daily life.

The diversion contract or court order should clearly specify what objectives must be met for treatment to be considered completed. They will include the resolution of the individualized issues outlined in the treatment plan and other predetermined program expectations, such as continuing progress in school, securing or maintaining employment, making restitution to the victim, and remaining AOD-free.

Accountability-based sanctions should be commensurate with the degree of noncompliance and proportionate to the degree of harm resulting from this noncompliance.

Judicial Responses to Treatment Issues

The role of the court is pivotal to the overall success of any juvenile diversion program. Not only do judges set the tone for actions that are initiated in juvenile courts, but judges also have a mandate to ensure that AOD abuse treatment diversion programs are developed and sustained. A judge's respect for and support of a treatment program and the elements of that program can, in fact, make or break a program. As noted previously in this chapter, the effectiveness of

treatment for a juvenile may depend on the authority and power of the court that orders the diversion. Thus, the court's requirement of accountability may support the treatment process itself.

Juvenile court personnel should be closely involved in designing the diversion programs. Juvenile court personnel, including special masters, referees, prosecutors, defense counsel, court services, and probation officers, should visit treatment programs to gain firsthand information about how the program is operating and insight into what the juvenile can expect from the program.

One way to support diversion programs is for judges and court services to assign priority status to diversion cases. With the crowded dockets that characterize many juvenile courts, this assignment can be difficult, especially since for every case prioritized, another is given lesser priority. The authority figure aspect of the judicial role is important, and one possible way to address the priority issue is for a jurisdiction to establish the position of a referee or special master to review diversion cases or establish a "drug court" approach to handling the AOD case.

Issues of accountability-based sanctions for noncompliance by youth in diversion programs must be handled expeditiously so that sanctions will closely follow noncompliant actions. In planning, it is necessary to allow the JJS to monitor, review, and support the performance of youth in AOD abuse treatment diversion and to return these youth to the court for further action in instances of noncompliance.

Uniform Eligibility and Acceptance Criteria

Individualization is an essential principle of the balanced approach used by the JJS. An AOD abuse treatment diversion program should be predicated upon the appropriate match of the juvenile to the necessary services. This match requires comprehensive, accurate, and timely screening and assessment, as well as preestablished eligibility and acceptance criteria so that arbitrary placement decisions are not made. The JJS goals and objectives in creating an AOD abuse treatment diversion program are that it be applied consistently and that appropriate

accountability sanctions be imposed for every criminal act. Planners should allow for ongoing review of eligibility and acceptance criteria, recognizing that changes in AOD abuse patterns and social structures (for example, gang activity) can occur in a community.

The need for uniform criteria can be illustrated by two contrasting examples of how a system should NOT function. Some treatment programs may accept all juveniles who are referred, in order to stay at full utilization (which may be a requirement to maintain funding). Their outcomes will probably not be positive because the juveniles have not been appropriately matched to the program. Other treatment programs may decide to accept only juveniles with the greatest chance for success (skimming). While their outcomes will be positive, this approach will not provide the AOD abuse treatment services that are needed for children, families, and communities, nor will it reduce the harmful effects of juvenile AOD abuse.

As the planning committee works to fashion a partnership between the juvenile justice and AOD abuse treatment systems, it is essential that the two systems agree on uniform eligibility and acceptance criteria and then adhere to them.

JJS Supervision of Youth in Treatment

In designing an AOD abuse treatment diversion program, planners should define the role of the JJS to provide the monitoring and support services necessary to ensure the juvenile's accountability. It is equally important that treatment staff understand this role. This deliberative process must include input from a variety of sources including judges, prosecutors, court services staff, probation officers, treatment providers, and former youth offenders and their families. If AOD abuse treatment staff are not involved in these deliberations as the diversion program is being developed, it will be much more difficult for them to buy into the process when the program is implemented.

A further design issue surrounds juvenile detention and probation standards that specify a certain staff/client ratio to ensure adequate security and supervision. Similar mechanisms should be established for treatment programs prior to program implementation so that both security

and case management concerns are adequately addressed. In some cases—for example, in a prefiling referral where there is no probation officer assigned to the case -- the primary supervision that is provided for the youth will come from the treatment provider. Planners might want to consider developing specialized court services units (trained to understand the nature of adolescent AOD addiction and treatment) to work with treatment providers in this capacity. The JJS is still responsible for monitoring the youth who, for example, are under supervision by a parent or grandparent or court volunteer who must report back to the court or to court services.

AOD Abuse Treatment System Decisions

Defining Treatment Expectations

In designing a diversion program for juveniles, planners should define a set of realistic AOD abuse treatment expectations. These expectations must be grounded in the realization that AOD abuse is a chronic, relapsing disorder. Realistic treatment expectations should not be confused with long-range goals. For example, a goal of zero tolerance of AOD use or of drug-free, crime-free outcomes is rarely a realistic AOD abuse treatment expectation, and establishing it as such only sets up clients -- and systems -- for failure.

Realistic AOD abuse treatment expectations establish objectives such as reduced AOD use, reduced deviant and delinquent behavior, improved school attendance and performance, and improved family functioning. Expectations must be individualized for each juvenile. The same treatment plan will not fit every youth. Universal, generalized expectations are impossible to meet. In planning, an understanding of this concept should be shared by all involved parties, so that an atmosphere can be created that is conducive to open discussion regarding realistic AOD abuse treatment expectations and expected outcomes.

The consensus panel recommends that collaborative groups planning juvenile diversion programs establish two mechanisms to define AOD abuse treatment expectations:

- **Cooperative agreements** between juvenile justice and AOD abuse treatment agencies define and explain what roles each will take in working toward achieving AOD abuse treatment expectations. These cooperative agreements (also called shared service agreements, memoranda of understanding, or qualified service agreements) should state what each agency is responsible for, capable of, willing to do, and able to tolerate. Providers of ancillary social services need to be part of the process of developing cooperative agreements. Because at least two separate systems will be involved in cooperative agreements, each community should establish a formal structure that brings the systems into active collaboration. One system may take the lead. Some jurisdictions may consider the use of a liaison from each agency to link services to facilitate this process. Others may want to identify a lead agency, select a program director, or use a case manager. To be fully effective, the local community must decide who is capable of bringing a comprehensive AOD abuse treatment diversion program into perspective and then into action, and, most important, who can sustain the community efforts.
- **Individualization** for each youth diverted from the JJS is specification of treatment expectations based on the youth's needs and the level of treatment available. Each juvenile's situation is defined by a unique set of circumstances and factors that have contributed to his or her behavior. The response by the AOD abuse treatment system to the juvenile should be individualized and related to an assessment of the unique contributing factors. These individualized case plans will list the sort of expectations described above as well as the juvenile's responsibility; for example, negative urine drug screens for a 12-month period, a grade point average improved by a factor of 1.0, no additional delinquency charges, and satisfaction of court-ordered restitution. These individualized case plans should list terms positively rather than negatively. For example, "I will

attend school regularly," is preferable to "I will not be truant." Presenting objectives in this positive framework helps contribute to positive outcomes. Court-mandated treatment plans or the case plan agreed to should be accessible to all personnel who are involved in the diversion program with the youth on a "need-to-know" basis only in accordance with Federal and State confidentiality rules.

In developing these reporting mechanisms, planners must remember that Federal confidentiality regulations protect information about AOD abuse treatment. In the case of the juvenile client, the parent or guardian sometimes must sign consent forms for the release of information. Confidentiality regulations are discussed in greater detail in the TIP entitled *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*.

Realistic AOD abuse treatment expectations establish objectives such as reduced AOD use, reduced deviant and delinquent behavior, improved school attendance and performance, and improved family functioning.

Defining and Locating Services

In planning a juvenile diversion program, it is important to define and locate the appropriate AOD abuse treatment services that are available within a community. The planning group should first ask what services are necessary to intervene effectively with AOD-abusing youths. Members should then determine which of these services exist and which are needed. Planners should define and locate those services in their areas that will be relevant to their program. It is important that juvenile court judges and juvenile court services personnel be familiar with AOD abuse treatment options, a goal that can be accomplished by invitation to personnel within the JJS -- including judges, court services staff, and prosecutors -- to visit AOD abuse treatment programs and establish contact with them.

Medically assisted treatment includes detoxification, methadone maintenance (which is rarely recommended for adolescents), or any type of treatment that uses psychopharmacology or a blocking agent to deal with the physiological addiction.

In different communities across the country, different types of treatment may mean different things. Regulations vary from one jurisdiction to another. For example, in one area, intensive outpatient treatment may be defined as a minimum of 9 hours of treatment a week; in another, it may be defined as a minimum of 15 hours of treatment a week. All terminology should be defined to ensure a common understanding. Throughout the development of this TIP, it has become apparent that common terms may have significantly different meanings to each systems collaborator. Legal terminology, for example, may have different connotations than the same terminology does when used in AOD abuse treatment.

The continuum of treatment services available for youth is described in detail in another TIP in this series, *Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents*. Services range from low-intensity outpatient treatment to intensive outpatient treatment (also called day treatment or day hospital services) to residential treatment or inpatient hospitalization.

Planners should also be aware that treatment options can contain a variety of components. AOD abuse treatment programs, for example, may include individual, family, and group counseling and psychoeducational sessions about the effects of AODs. AOD abuse treatment may be psychosocial in nature, or it may be medically assisted. Medically assisted treatment includes medical detoxification, methadone maintenance (which is rarely recommended for adolescents), or any type of treatment that uses psychopharmacology or a blocking agent to deal with the physiological addiction.

Some AOD abuse treatment programs include an assortment of treatment options. A "one-stop shopping" approach offers a range of treatment services, especially in large urban areas where many AOD-involved juvenile offenders have a complex variety of treatment needs. One-stop shopping means that a youth will have access to an entire array of services located at one site.

Some communities may take one-stop shopping a step further to institute universal intake procedures, establishing a collaborative approach among a number of agencies, which makes it easier for youths to gain access the various services they need, including family, social, psychological, medical, and educational services as well as AOD abuse treatment. For youths with multiple problems, this approach can help avoid the fragmentation that often comes from being involved with multiple service providers.

Some communities, however, will have few if any AOD abuse treatment services specifically designed for youth. This problem can be compounded by the reluctance of treatment programs that do serve youth to provide treatment for juvenile criminal offenders. The planning committee must identify service gaps and recommend the creation of appropriate services. This is an important needs assessment function, even in communities that have some services. A system cannot be planned without accurate and up-to-date information about what services exist, what services are needed, and how they can be made appropriate, accessible, and affordable for youth and their families.

Identification of services should not be limited to those that are AOD-related. As noted above, many of the youth in diversion programs have a wide range of biopsychosocial needs, and those on the planning committee who are investigating the availability of services should look at adjunct services that cover areas such as job training, emancipation issues, medical needs, "clean and sober" support programs such as Alcoholics Anonymous and Narcotics Anonymous, and mental health treatment services.

Screening and Assessment for AOD Abuse Treatment Referral

Personnel who are familiar with the standardized instruments available for AOD screening and assessment of juveniles should take part in the planning process. State-of-the-art tools should be used for screening and assessment, and standardized tools should be agreed upon before the implementation of the diversion program. Another TIP in this series, *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, discusses this subject in detail and includes a number of sample instruments designed for use with juveniles.

Screening helps determine the need for further assessment or direct referral to crisis health or mental health services. Screening should not be limited to AOD use but should briefly cover a broad range of health, mental health, and social issues that may require some sort of rapid intervention. Testing for AOD use at the time of arrest is a valuable screening tool, but the result is just one of several factors to consider in making decisions. A positive urine screen is an indicator of AOD use at one particular point in time; it should not be used as the sole determinant of whether a youth does or does not have an AOD problem. Even negative results should alert the assessment team to the need to further explore the possibility of AOD abuse if other indicators are present -- past AOD-related offenses, a drug-using peer group, or chemically dependent family members. If the result is negative and other factors show no indication of AOD abuse, the youth should not be referred for AOD abuse treatment.

Some juveniles who are not involved with AODs may claim to have AOD problems because they perceive this as a way to avoid being detained or incarcerated or to gain status with their peers. This behavior affects the JJS and AOD abuse treatment systems in two ways. Accountability under the law is essential, and an accountability approach should not allow youth to use AOD abuse as an excuse to escape the sanctions for unlawful behavior. AOD abuse treatment programs do not want these youth referred.

To avoid the risk of diversion being wrongfully applied, assessment must play a major role in any diversion program. It should be performed as soon as possible after the precipitating event (for example, the arrest). Screening and assessment should be initiated and coordinated in conjunction with the intake process within the juvenile court. When a juvenile diversion system is being planned, the role of assessment should be considered an integral part of the comprehensive diversion and treatment process. The more sophisticated the assessment process, the more successfully youth will be placed. Assessment does not end with placement. It is not a single event but should be viewed as an ongoing part of the AOD abuse treatment process.

Screening should not be limited to AOD use but should briefly cover a broad range of health, mental health, and social issues that may require some sort of rapid intervention.

When planning a juvenile diversion system, it is important to address appropriate training of personnel who will be doing screening and assessment. Assessment should be closely tied to treatment planning and to outcome evaluation. Most juveniles will not be in clinical withdrawal when they come to the attention of the assessor, but some may be. Procedures should be established so that these youth can be easily referred immediately to a detoxification program.

Planning To Deal With Issues of Culture, Gender, and Ethnicity

Cultural, gender, and ethnic sensitivity are important aspects of both juvenile justice and AOD abuse treatment. It is necessary that the JJS and the AOD abuse treatment system understand the need to incorporate cultural, gender, and ethnic concerns into the disposition and treatment of juvenile offenders. Training programs and in-service training in the development of cultural competency should be available for policymakers and personnel throughout both the JJS and AOD abuse treatment systems. AOD assessment and evaluations of youth to determine disposition should be performed by personnel competent in dealing with specific cultural, ethnic, and gender issues that may affect the interaction.

Among the aspects of cultural diversity that may influence and affect juvenile justice and AOD abuse treatment are language, ethnic background, gender, spiritual or religious beliefs, attitudes toward healing, family systems, social norms, and physical and emotional disabilities. The procedures developed by the planning committee must be sensitive to diverse cultural, ethnic, and gender issues; courts should be acquainted with the body of research demonstrating the efficacy of cultural competence.

While some accountability-based sanctions may be viewed as punishment by some youth but not by others, these views may relate to the youth's culture and background. For example, youth involved in gang culture may perceive referral to a correctional institution as a means of gaining status in the gang rather than as a punitive measure. Dealing with these perceptions will pose difficulties for juvenile judges and juvenile court services attempting to apply justice consistently and appropriately, but still must be considered.

An aspect of culture that should be considered in the context of diversion to AOD abuse treatment is the strength of family structures found in many cultural and ethnic populations in the United States. Effective parenting and family support can be a major influence that deters children from using AODs. These strengths should be drawn upon in building a program. For example, in today's society, where youth are often searching for identity and values, the traditionalism embodied in the Native American family, which respects the position of its elders, is a value that can be used by an AOD abuse treatment program as an illustration for all participants.

Elders are a resource not just in Native American populations but also in many other groups, and they can be of assistance in planning diversion programs—not only culturally specific programs but also broad-based ones. Elders with experience to contribute can be actively recruited through organizations, through networking, and through other means to take part in the planning process.

Employing these resources can help expand the idea of what treatment means and can help increase awareness of the value of alternative forms of treatment. Examples of Native American treatments include sun dancing, cleansing rituals, cultural meditation, sweat houses, and medicine singing. The African American community's rites of passage for young males include traditions that can be adapted to the treatment context and can increase the positive bond to the cultural community.

In establishing the planning committee, attention should be given not just to potential members' academic degrees but also to life experiences.

Gender-Specific Treatment

While the incidence of female delinquent behavior is lower than that among males, there is little difference in their crime patterns. However, the young female offender is underidentified in the larger context of the juvenile offender population. Official statistics show that girls are arrested far less frequently than boys, and then for relatively minor offenses.

Most research and practical experience with juvenile offenders have been with males, and JJS program designs range from the farm, ranch, or forestry camp to the paramilitary ("boot camp") models. Females may not easily fit into these programs, and the relevance to females of these male-oriented program designs has proven inconclusive. Male and female juveniles are likely to respond differently to accountability-based treatment strategies and thus need to be approached differently. Fortunately, data exist regarding gender-specific treatment approaches. Among other differences, programs for female clients must supply a range of services not needed in programs for male clients, including child care, parenting classes, feminine hygiene supplies, baby supplies, and access to obstetric and gynecologic services.

Because of the special needs of young women, which may include prenatal and child care, it is more expensive to treat them, and many treatment programs have been wary of accepting them. While the number of slots needed for young women may be only a fraction of the number needed for young men, the rapidity with which slots for young women are filled when they are made available is convincing proof of the need for them. A continuum of services for young women similar to the continuum of services that already exists for young men is needed. Treatment models must be sensitive to the gender-specific needs of the population, including the availability of female staff to work with young women. For example, while many young male-oriented delinquency intervention models (such as boot camp regimens or VisionQuest) stress confrontation, nonconfrontational models may be more suitable for young female offenders. See *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs*, a publication of the CSAT Division of Clinical Programs, Women and Children's Branch.

Male and female juveniles are likely to respond differently to accountability-based treatment strategies and thus need to be approached differently.

Continuing Staff Development on Issues of Diversity

Staff training improves understanding and awareness of resources. It would be valuable for AOD abuse treatment providers, together with judges and juvenile court services personnel, to share a cultural diversity curriculum so that each can develop some common understanding of

culturally sensitive issues in their community. This understanding must be specifically developed by each community and should be done on an ongoing established basis.

Another important part of the planning process is to survey and analyze the social and cultural indicators in a needs assessment, which should address issues of cultural diversity with an accurate, up-to-date list of existing resources that support youth and families participating in an AOD diversion program. Such a list can provide insight into what needs are met in a community, where more attention must be focused on policy, and the continuing development of the AOD diversion program.

One way to address issues of cultural diversity is for both the juvenile justice and AOD abuse treatment systems to include staff who are representative of the populations being served (for example, women should be available to work with female offenders). It is also important to recognize that just because an individual represents one cultural, racial, or ethnic group, this does not mean he or she is sensitive to all issues of that group. For example, African Americans are a diverse population in this country, and some black people (for instance, Haitians) are not African American. Some communities may be dealing with cultural differences within the same racial or ethnic group or among recent immigrants into a large established ethnic community.

Community Health and Social Services Decisions

Establishing Referral Procedures

Procedures must be established for the referral of juveniles between the AOD abuse treatment system, the JJS, and the community health and social services agencies that will provide services to the youth in the AOD abuse treatment program.

Each participating agency should clearly define its target population, the array of services, and fees for service, and specify all limitations. The collaborating committee may be able to negotiate a simplified linking system. Many agencies have developed quite elaborate referral information requirements to assist in providing services to the most appropriate youth. Often these

requirements are so stringent as to be insurmountable barriers to service. To help achieve the goal of a "seamless" service system and decrease duplication of effort, a single referral document should be developed for all participating agencies.

The importance of an easily understood and simple referral process cannot be overemphasized. In a fully integrated system, services are matched to the identified needs of the youth and his or her family. Each service becomes essential to the achievement of a positive outcome.

Sufficient care should be taken to acknowledge and support the specialized requirements of some services. The diversion program's effectiveness or funding support may be based on some specific limitations or documentation requirements. Other programs and services are effective for a specific subgroup of youth, and not acknowledging their uniqueness may compromise a valuable service.

Considerations in Treating the Family

Although families are the first level of responsibility in our society, the family's economic status can be another influencing factor to consider in program development. Juveniles from middle-class families, with well-established networks of financial supports, may benefit more from AOD abuse treatment and may have better outcomes than juveniles from poor families with less developed support networks.

It is also important to note that a family's commitment to getting treatment for its youth should not be related to socioeconomic factors. Parents should be included in all decisions regarding the youth. AOD abuse treatment programs should actively engage the family in participation in the youth's treatment plan. Families should see their role as part of the solution, not just part of the problem. AOD abuse treatment providers should be skilled enough to alleviate the fears of entering treatment or receiving services that are expressed by many youth and their families but, when appropriate, there should be no hesitation in mandating that family members actively participate.

Defining the Role and Expectations of the Family

The family plays a key role in the youth's behavior, activities, and attitudes in the AOD abuse treatment diversion program, and it is important that "family" be defined as broadly as necessary to encompass different arrangements and living situations. A family may be defined as those individuals who provide shelter, nurturance, and guidance for a child. The Commission on Families of the National Association of Social Workers defines a family as two or more people who consider themselves a family and who assume obligations, functions, and responsibilities generally essential to healthy family life. The functions of the family include child care, child socialization, income support, long-term care, and other types of caregiving.

This concept goes beyond that which is traditional for the biological family (mother, father, and siblings) and includes a wide variety of possible arrangements. Examples of families include a grandmother and her grandchildren; a single mother, her children, and her boyfriend; and foster parents raising several children. Family support can come from a community elder or from a recovering adult. Children may also get family-like identity and support from friends, or even from gangs, although support from the latter is not considered healthy.

Ideally, parents (or individuals filling the parental role) should participate in the treatment process. It is difficult for the youth to progress without family involvement. Whoever is identified as the family of a youth who participates in the diversion program must make a long-term commitment to the treatment and recovery process. The family should have a physical presence in youth diversion programs because parents remain responsible and accountable under the law for their child's activities and behavior. Family members should participate with the youth in the diversion process. The diversion agreement or court order should specify incentives for family participation in treatment and the expected benefits to the family when the youth successfully completes treatment.

Defining appropriate expectations for the family is an important part of the diversion plan. Ideally, family members should understand how critical their role is and be supportive in all efforts. At a minimum, the family should participate in the development of the diversion plan, sign the diversion agreement, or be a party to the court order, monitor it, and report to a contact person on either compliance or noncompliance by the juvenile. Contact persons could be court

services staff members such as probation officers or case managers or AOD abuse treatment providers.

The family plays a key role in the youth's behavior, activities, and attitudes in the AOD abuse treatment diversion program and may be defined as those individuals who provide shelter, nurturance, and guidance.

Families must recognize that their own response to the juvenile's AOD problem may be inappropriate, and members should be willing to seek assistance in developing parenting skills, addressing their own AOD problems, and dealing with vocational and educational issues. Parents should recognize what puts their children at risk, and should address that risk. One example is teaching a juvenile conflict resolution skills; it is only marginally useful for a juvenile to learn alternative ways to solve problems if parents and other family members are not also instructed in these skills. Families also can facilitate treatment by providing transportation, babysitting for teenaged mothers in treatment, and being an active and informed advocate for youth in treatment.

Family involvement is a significant contribution to the success of AOD abuse treatment, but it may also prove problematic in some situations. For some youth, the risk factors within the family are a substantial part of their problem. For example, if the juvenile is a third- or fourth-generation AOD abuser, removing the juvenile from the home may offer the best chance for success in treatment. Sometimes, families will not cooperate with treatment. Recognizing that authority to mandate treatment for family members varies from jurisdiction to jurisdiction, the consensus panel recommends that where there is no authority to mandate family participation, States consider enacting legislation that would allow courts to order parents to comply with AOD abuse treatment diversion, when appropriate.

It is important that a youth not be penalized or excluded from diversion opportunities because of the lack of a responsible or cooperative family. When necessary, the court should arrange for a relative, a guardian *ad litem* (for the particular action or proceeding), or a foster family to fulfill the role of the family.

Management System Decisions

Funding

The National Center for Service Integration identifies four principles that form the foundation for strategies to finance new service systems. These principles should be set forth in the implementation manual and referred to throughout the process of developing, financing, and implementing the diversion program:

1. Financing should reflect and reinforce a new set of principles and characteristics for service delivery and should be driven by a compelling and well-conceived program agenda.
2. Effective fiscal strategies should incorporate multiple funding sources and cut across traditionally separate service domains.
3. Financing strategies should make use of dollars already being expended in the service system.
4. Fiscal changes require parallel alterations in service governance and service delivery technologies if they are to be effective (Farrow and Bruner, 1993).

When considering the funding of AOD diversion programs for juveniles, cost and funding sources must be considered, including the use of nontraditional sources and reallocation of current resources. The impact of healthcare reform on AOD abuse treatment resources is another important consideration.

Cost Considerations

AOD use endangers not only youth and families but the community as well. However, both the costs of the AOD abuse to a youth's life, liberty, and property and the cost that is offset by AOD abuse treatment must be considered. Costs of AOD abuse include 1) human costs, 2) economic

costs, 3) physical healthcare costs, 4) mental healthcare costs, 5) criminal costs, 6) morbidity, 7) increased social welfare costs, 8) loss of work production, and 9) loss of education.

The benefits of AOD abuse treatment are many, with successful treatment offsetting potential expenditures in all of the above categories. Numerous studies show that every dollar spent on treatment leads to a sizeable reduction in AOD abuse and that criminal behavior declines as a result of treatment (Young, 1994).

Funding Sources

The identification of funding sources available for diversion programs should be a priority in the planning process. Since diversion programs will integrate services from several systems (JJS, AOD, and community health and social services) with separate funding streams, it is important that representatives from all the systems who are familiar with the funding streams be part of the planning team.

Funding sources might include Federal block grants, specially designated funds from the State legislature; county and community grants; Medicaid; private and public foundations, health insurance; local businesses; client fees; family and memorial foundations; the United Way; the Job Training Partnership Act; and the Office of Juvenile and Delinquency Prevention, Department of Justice, for training court personnel. Revenue sources could be derived from community fees, fines, levies, and forfeitures resulting from drug trafficking and other criminal offenses associated with AOD abuse.

Although AOD abuse treatment is expensive, new dollars are not always necessary to fund diversion programs. It may be a matter of being innovative or creative. Sometimes reallocation of current resources, both financial and human, can go a long way toward funding services. If the major partners in the systems develop cooperatives that combine their existing resources, many needs may be met. The development of working partnerships can lead to shared staff, relocation of staff, and reallocation of existing AOD resources to the target population.

As public funds become less available, communities are given the opportunity to reconfigure current systems. The collaboration should address funding issues from the viewpoint of what services the funds can purchase. Only then can the true lack of fiscal resources be documented.

Making use of volunteer services is another way to augment traditional funding sources. Volunteers can assist with followup, tracking, and case management tasks. As previously noted, community elders can be a valuable source of volunteer efforts. Recovering youth can serve as mentors to youth just entering the treatment system. (Youth volunteers should always be monitored by adults.)

Planners should be aware that the use of volunteers may involve some costs and can raise procedural problems. Developing volunteer services requires the development of clear procedures and guidelines covering what a volunteer may and may not do. Screening, training, and insurance coverage for volunteers are issues that must be considered. For example, residential programs may discover that their liability insurance covers only paid employees and not volunteers. Confidentiality rules may pose a barrier for the use of some types of volunteers. Juvenile justice and AOD abuse treatment planners should turn for guidance to both private and public agencies that have experience working with volunteers.

At a minimum, the names of volunteers should be screened through the National Crime Information Center database, Federal and State criminal records, and child abuse registries. Procedures for performance evaluation of volunteers should be in place, as well as formalized training and ongoing supervision. Clear guidelines should be established for transporting youths, or for any other situation that may involve potential liability or security issues. Recruiting and training volunteers should be ongoing processes, and agencies should consider funding a position for a staff member to do these tasks. Recognition programs to acknowledge the contributions of volunteers should also be planned periodically.

Creative use of other nontraditional sources can also help fund diversion programs. A potential significant resource may be found in the physical facilities of established institutions. Schools, businesses, or government facilities can be used to house programs. For example, schools might

be kept open during evening hours for parent training programs or other after-hours programs or to provide office space for onsite AOD abuse treatment. Use of these resources can result in significant savings in operational costs.

Another possibility is to explore incorporating existing programs into diversion efforts. For example, Boys' and Girls' Clubs in some regions sponsor tutorial programs. In other parts of the country, local exchange clubs, service clubs dedicated to youth issues, sponsor parenting classes and child advocacy projects. Building on existing programs in the community avoids duplication and overlap and brings community organizations into worthwhile partnerships with the juvenile justice and AOD abuse treatment systems. However, these organizations should be involved in the planning process so that they can commit the resources they have available. Another nontraditional means for obtaining funding is the specific allocation of community taxes on gambling, alcoholic beverages, or cigarettes. Future healthcare policy reform at State and perhaps national levels is likely to affect these funding issues profoundly. Planners of juvenile diversion systems should be mindful of the forces that will be shaping healthcare policy on both the State and national levels. As healthcare policy is being developed, special attention should be paid to how youth programs will be covered and to what extent AOD abuse treatment will be covered by new healthcare proposals.

Confidentiality and Adequate Communication Between All Parties

Adequate communication is extremely important to a collaboration such as that of the planning committee. Communications regarding AOD abuse treatment are strictly regulated by Federal confidentiality regulations (42 C.F.R.), although it may sometimes seem that the concepts of confidentiality and communication are mutually exclusive. For example, without express written consent, an AOD provider may not be able to notify the court that a diverted youth failed to enter treatment. Planners should be open, creative, innovative, and focused in developing information sharing strategies within the confines of the rules.

To be effective, court-mandated treatment plans must be monitored to ensure that the diverted juvenile is participating as required and that the diversion program is meeting the juvenile's

needs. Thus, sharing of information is an issue that should be addressed specifically and comprehensively in the planning process. A key to overcoming communication problems is to build trust among all the agencies involved. The regulations define arrangements that facilitate the sharing of information. For example, qualified service organization agreements, as described in the Federal regulations, allow for the sharing of information in relevant situations.

Communications regarding AOD abuse treatment are strictly regulated by Federal confidentiality regulations (42 C.F.R.), although it may sometimes seem that the concepts of confidentiality and communication are mutually exclusive.

The basis for decisions regarding confidentiality and communication should be the best interest of the youth. The question that should be asked is: What information sharing is necessary to determine the best treatment and disposition for the youth? Information should be shared in order to 1) avoid duplication of services, 2) ease the youth's access to services, 3) ease intake, 4) facilitate planning, 5) encourage informed decisions, and 6) positively influence outcomes.



Exhibit 4-2 The Written Report

Exhibit 4-2 The Written Report

The written report should identify

- The severity of the AOD abuse
- Factors that contribute to or relate to AOD abuse
- A corrective action plan to address problem areas
- A detailed plan to ensure that the treatment plan is implemented and monitored to its conclusion.

The written report should be careful to

- Not reduce a youth to a test score
- Emphasize the youth's strengths as well as problems
- Capture the full range of issues, strengths, and concerns relevant to the youth
- Integrate previous workups when they indicate progression of symptoms and problems
- Not include opinions and descriptions from previous reports without thought and research--the report can follow the youth for years.

The written report should be distributed

- On a "need-to-know" basis only in accordance with Federal and State confidentiality rules
- Only with the signed approval of the adolescent (and, in some States, of the parent or guardian), as required by Federal or State laws.

The report should serve as a basis for linking youth with needed services.

- It should specify treatment placement recommendations.
- It should recommend posttreatment support services.

Note: The report should be written so that it can be understood by the youth and all parties concerned.

Decisions regarding confidentiality and communications should not be made unless the following issues have been carefully addressed:

- All agencies that have a need to share information concerning each youth should be involved.
- The reasons why the agency needs the information should be documented. For example, much evidence exists regarding widespread child abuse in the AOD-involved delinquent youth population; this documentation is necessary for a "need to know" of the abuse history

recorded at various agencies involved with a youth. Relevant child abuse reporting statutes should be included in this discussion.

- Agencies must agree that the needs for shared information are acceptable, relevant, and nonthreatening to the youth.
- What information is each agency willing to share, and with whom?
- How best to protect specific information that one agency does not wish to share or is restricted from sharing (such as HIV status) must be resolved, with clearly established boundaries set as part of the planning process.
- The purpose of confidentiality (to protect the youth) must be reinforced. In some circumstances, confidentiality regulations may protect the system, not the youth.
- An approach to the changing policies and regulations that prohibit sharing of information must be developed.
- Automation of information with interagency access must be addressed. Current sophisticated computer systems can facilitate this. Information-sharing software is in the public domain, and jurisdictions should consider state-of-the-art management information systems that are available by modem.
- Procedures for uniform sharing of information must be developed. This process can be conducted incrementally, a piece at a time, beginning with the least sensitive information to be shared.
- Uniform informed-consent guidelines and forms must be developed. When possible, these guidelines and forms should be automated to ensure interagency access and protection.

See [Exhibit 4-2](#) for some specific examples.

System Management Issues

System management refers to the ability to effectively plan, implement, and maintain AOD abuse treatment alternatives for JJS-involved youths. It includes the following components: 1)

program management capabilities, 2) system oversight and organization, and 3) interagency cooperation and collaboration.

Program Management Capabilities

Licensure and other approvals are the foundation for a system of AOD abuse treatment services, and planners of juvenile diversion programs should carefully examine these requirements. It is important that they not plan services that require complicated licensing procedures that current providers may not be capable of achieving or cannot afford. An example is the accreditation of residential programs that is provided by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Attaining this accreditation may present formidable barriers in some cases. A different sort of example is the nonprofit status that is required of agencies wishing to receive some grants.

Third-party billing capability is another important concern. A third-party payer is an insurance company, managed care organization, health maintenance organization, or similar entity. (First-party payers are clients themselves; second-party payers are government sources such as Medicaid and Medicare.) Planners should assess current service providers' abilities to participate in third-party billing, which is often essential to the establishment of a consistent funding stream.

Past experience with the target population is another management issue that will be indicative of program management capabilities. Adolescent services are difficult to provide, whether they are AOD-related, educational, psychological, or social. In looking for programs to incorporate into a juvenile diversion system, planners may want to focus on organizations that have experience and expertise in providing services to the target population. An agency's experience in providing AOD abuse treatment services for adults does not necessarily qualify that agency to provide similar services for youth. It is also true that treating AOD-abusing delinquent youth may call for different skills and resources than those that are needed for treating either of these populations (AOD-abusing youth and delinquent youth) separately.

This requirement does not mean that programs that do not have a history of treating the target population should automatically be excluded from involvement in the development of a juvenile AOD abuse treatment diversion program. However, programs and system planners must be aware of the particular challenges in treating this population and seek technical assistance when necessary before implementing a diversion program.

When systems are brought together, it is necessary to continue the process of identifying what individual or agency is responsible for which service or product. Planners should define explicitly which agencies will have oversight and responsibility and under what circumstances. Monitoring procedures, governmental regulatory activities, and site visits should be planned carefully. These monitoring activities should cover not only established programs, but also programs that may have started informally in churches or community facilities and escaped oversight processes.

When systems are brought together, it is necessary to identify what individual or agency is responsible for what service or product. Planners should define explicitly which agencies will have oversight and responsibility under what circumstances.

Comprehensive reviews of how components work together should be scheduled periodically. Programs and their progress should also be reviewed regularly, with more frequent reviews earlier in the development of the program.

System Oversight and Organization

Program oversight and organization can present difficult challenges. System organization and oversight can be even more difficult. That is the nature of collaboration.

A critical component to the functioning of the interrelated services is an advisory board of representatives of all the services involved in the diversion program. This board should be relatively small to allow for efficiency of operation, and it should have staff support (donated by one of the agencies involved) to notify members of meetings, keep minutes, and perform other administrative tasks.

An advisory board can begin its work by adopting a clear vision statement, establishing a scope of work and appropriate procedures, and electing a structure of leadership. It should conduct meetings according to an agreed format, which will facilitate translating ideas and recommendations into action. The board should be aware of barriers that could interfere with its work. One example is the hidden agendas of participants. If the board can acknowledge that there are hidden agendas and be sensitive to them, this may offset potential negative effects.

Another barrier that often arises is the inclination of people to protect their institutional and organizational "turf." To plan for that, advisory board leaders should focus early on preventing turf issues from stalling the planning process. They should meet individually with key stakeholders and identify and discuss their needs, concerns, and support. A clear, concise agenda will help avoid setbacks and misunderstandings.

Interagency Cooperation and Collaboration

As emphasized throughout this TIP, interagency cooperation and collaboration are the critical elements in developing a successful juvenile diversion program. It is essential at every point in the planning process.

Written Documentation

Documentation of program design and operating policies and procedures is an essential part of a juvenile diversion program and should be incorporated into the planning process. In order to operate smoothly, programs should reach consensus on procedures and guidelines and have them in place before they begin taking referrals. This written documentation covers issues large and small, ranging from general policy to detailed procedures regarding specifics, such as program check-in and security measures.

A policies and procedures manual for AOD abuse treatment providers should be approved by the provider's overseeing agency and should be open for review throughout the planning process. In most cases this approval and review will not involve extra work for the treatment provider, since

AOD abuse treatment agencies are usually required by current licensing and oversight agencies to develop policies and procedure manuals.

However, additional efforts will be required on the part of the juvenile justice and AOD abuse treatment communities to agree upon written procedures for referrals from juvenile justice to AOD abuse treatment. The procedures described should be specific and should address questions such as what the role of a court services officer is in making a referral, whether treatment programs should maintain a physical presence in the court in order to facilitate diversion, and which forms should be shared among cooperating agencies.

Preimplementation Training and Public Education

The need for training and cross-training -- multidisciplinary training that raises awareness of the philosophical approaches, skills needed, and tasks performed by staff in JJS, AOD, or physical and mental health and social services -- of all personnel involved in a juvenile diversion program is central to the success of the program. It is only through cross-training that the different perspectives of the JJS, the AOD abuse treatment system, and other involved agencies can be reconciled.

One way to accomplish this reconciliation is to establish a broad-based curriculum in a training institute that includes trainers from courts, law enforcement, AOD abuse treatment agencies, and schools to provide training sessions for all involved personnel. While much of the curriculum will be relevant to all participants, specific lessons may be directed to specific participants. For example, prosecutors and other court personnel should be instructed in the nature of addiction as a chronic, relapsing disease, while treatment providers should be taught about public safety, law enforcement, and juvenile justice procedures.

Conflict resolution should also be a component of the comprehensive training program. Part of teaching juveniles to deal with addiction is teaching them how to deal with conflicts, and program staff also should learn conflict resolution and anger management in order to work most

effectively with their clients. These strategies could also become the basis for resolving inevitable interagency staff conflicts.

The consensus panel acknowledges that training can be an expensive process but believes it is a valuable and essential one. Expenses can be moderated by using a number of techniques. Local universities can be a source of interns or volunteers. State-of-the-art technology such as teleconferencing can present a program to widely scattered participants without requiring them to be at the training site. Local cable access and educational television stations can further broaden access to training by reaching community members, including parents and family members of juveniles who are involved in the programs. Informal training programs, such as "brown bag" lunches, where staff with specific expertise can make brief presentations, has many extra benefits. The programs acknowledge staff expertise and allow staff from the other participating agencies to experience the depth of local knowledge. Often local agencies and their staffs tend to discount their knowledge and level of skill.

Conflict resolution should also be included in the comprehensive training program.

Printed media can play a role in public education efforts, particularly on the community level. For example, resource guides can be developed and inserted in local newspapers. Hospitals and schools can also distribute printed material to help educate the public about addiction and delinquency.

System Evaluation

Evaluation is a facet of program design that should be considered from the first phases of planning. Good programs require systematic evaluation, and good evaluation requires an investment of personnel and financial resources. Experienced evaluators should be involved from the outset. An effective evaluation design must begin with program development in order for results to be objective and unbiased.

Many field reviewers of this TIP were concerned about the ability of communities to secure adequate evaluation resources. There are many untapped resources even in isolated rural

communities. State universities have been increasingly involved in providing technical resources to the rural areas of their States. Rural medical outreach training programs bring medical and nursing students to underserved areas. Most of these programs have large research and evaluation departments, and the uniqueness of the evaluation may be attractive to them. In addition, linkage to the State higher education system can be made through the local extension and 4-H agent.

The evaluation component of the diversion program should be designed by an individual who is not only experienced in evaluation but also familiar with the fields of juvenile justice and AOD abuse treatment and who has a clear understanding of the goals of the programs and systems involved. The evaluator must be sensitive to adolescent, family, community, and cultural issues. Further, there must be an understanding by the evaluator of the type of data that must be collected in order to measure system performance, not individual program or client outcomes. If an independent evaluator is contracted, the specifics of these data needs should be spelled out in the contractual agreement, along with a timeline for all anticipated reports and a clarification of ownership of the data.

Many elements are involved in the design of an outcomes monitoring system, and this document can sketch only a broad outline of that process. Design and implementation of outcomes monitoring systems are described in detail in another TIP in this series, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*.

In evaluating the results of a juvenile diversion system, two primary outcomes will be measured—relapse in AOD use and recidivism in illegal behavior. These outcomes may mean different things to juvenile justice and AOD abuse treatment personnel, and clear criteria for successful outcome measures should be identified and established during the planning process. Neither relapse nor recidivism are absolutes, and outcome measures should recognize this important point.

Evaluation requires collection of data at intake, and a number of standardized instruments in the public domain are available for this purpose. (The TIP *Screening and Assessment of Alcohol- and*

Other Drug-Abusing Adolescents includes an appendix with several of these instruments.)

Followup data should be collected 30, 60, and 90 days and 1 year after completion of treatment. Collection of data related to the youth's offending behavior does not require a formal court review, but can be based on reports from, for example, a juvenile justice case manager. Urine screen results or self-reports to identify relapse will usually come from AOD abuse treatment providers.

Outcome data must be tied closely to AOD diversion program expectations, which have been determined on a community-by-community basis. Individual interpretation is what makes evaluation successful; this is a particularly important point in the context of juvenile diversion, where success and failure are not always clear concepts. For example, while reinvolverment or reentry into the JJS may seem a negative outcome, some individual diversion contracts may provide that reinvolverment or reentry for a lesser offense than the original arrest will be considered as some measure of improvement. Likewise, one positive urine screen is not necessarily interpreted as failure if a contract stipulates that a youth must have, for example, no more than one positive test every 3 months. In addition to AOD abuse and law-offending behavior, other outcomes that can be measured include school performance and family functioning.

Because diversion programs are usually time limited, it is important that evaluators measure outcomes beyond the formal termination of the AOD diversion. It is only with such data that determinations can be made about the overall success or failure of the AOD abuse treatment diversion program.

Evaluative data should be kept in an accessible and useable format. In most States, a single State agency has the responsibility of collecting AOD-related data and reporting it to the Federal Government to determine distribution of block grant funds. These data can provide a foundation for system evaluation. Uniform crime reports collected by law enforcement officials and State crime prevention offices can also serve as part of a foundation for evaluation.

Evaluation should be sensitive to issues of culture, gender, and ethnicity, with an appreciation of the cultural nuances and subtleties that may be involved. Cultural competence requires knowledge about cultural issues and distinctions, awareness of how they affect a community, and sensitivity to the specific needs of cultural groups.

Ongoing Research

Research consistently shows that criminal behavior and juvenile AOD abuse are strongly correlated. System evaluation can lead to ongoing research, which can help a community develop a unified juvenile diversion program. Currently, there is a sparsity of existing research on diversion programs. More is needed to determine whether diversion assists the JJS in reaching its goals and whether it leads to positive long-term outcomes for youth, their families, and the communities in which they live. The consensus panel recommends that all efforts to develop interagency diversion programs place a heavy emphasis on research and evaluation.

Research and evaluation are essential to ascertain what kinds of programs work and -- just as important -- what kinds do not work. Research information based on valid evaluation should be widely disseminated so that successful projects can be replicated and poorer models avoided.

Summary

This chapter has addressed the many issues that are critical to comprehensive planning for a system of diverting AOD-abusing youths from juvenile court interventions to AOD abuse treatment. One of the most critical tasks (and perhaps the most difficult) is to arrive at a broad consensus regarding what is meant by diversion in this context. This concept must be defined unambiguously and all of the planning partners must endorse the definition.

Other critical planning issues that were addressed included the identification of the appropriate target population for diversion, appropriate diversion points, and key system leaders to be involved in the planning process. In addition, effective planning requires attention to such diverse issues as 1) screening and assessing, 2) attaining adequate funding, 3) managing

confidentiality while adequately sharing information, 4) designing and documenting an AOD diversion system, 5) using system management techniques, 6) training staff, 7) evaluating effectively, and 8) conducting ongoing research and development.

Chapter 5 synthesizes much of the material presented here. That chapter provides a summary of the tasks that must be accomplished in developing an operations manual for implementing a collaborative program—a program for diverting AOD-abusing youths from the JJS to appropriate AOD abuse treatment.

TIP 21: Chapter 5 -- Program Implementation Issues

Previous chapters discussed the goals of alcohol and other drug (AOD) abuse treatment diversion programs and addressed the planning issues in developing these programs. This chapter provides a review of the basic activities required to implement a program for diverting appropriate AOD-abusing youth from the juvenile justice system (JJS) to appropriate AOD abuse treatment.

Developing an Implementation Manual

One way to facilitate the implementation of the program is for the planning group to develop a manual outlining each step required to establish a successful AOD abuse treatment diversion program. The implementation manual must clearly explain 1) lines of authority, 2) the functions and responsibilities of the AOD abuse treatment system, 3) linkages between community agencies and the JJS, and 4) methods by which the costs of treatment and referral services will be reimbursed.

This manual will document the purposes, goals, objectives, and intended activities of the program. It is an effective way to demonstrate that the program is endorsed by the key system components: the JJS; AOD abuse treatment services; community physical and mental health

services and social services; and community representatives. Representatives of the collaborating groups will change over time and the individuals responsible for implementing a program may not have been involved in planning it. Development of an implementation manual will ensure that the program operations remain consistent with the decisions reached by the planning group.

Many types of information should be included in the implementation manual. The manual should provide clear, concise information to help everyone understand the goals and objectives of the diversion program as well as all system components, including referral organizations in physical and mental health and social services. Procedures for referral between agencies should be spelled out. Similarly, procedures for interagency dispute resolution should be described. The responsibility of the lead agency should be set forth clearly, and the manual should specify the sources of funds that will have to be obtained throughout the life of the diversion program and the procedures for obtaining these funds. Funding should be discussed early on; too many diversion program planners make the mistake of not focusing on obtaining new funding until it is too late.

The manual should describe the criteria for selecting youth eligible for admission to the AOD abuse treatment diversion program, along with screening and assessment procedures for youth identified as potential candidates for diversion to AOD abuse treatment. The continuum of services should be described and explained.

The image is a small thumbnail of a document titled "Juvenile AOD Abuse Treatment Diversion Program Checklist". It appears to be a table or checklist with multiple rows and columns, likely detailing various tasks and criteria for the program. The text is too small to read in detail.

Exhibit 5-1 Juvenile AOD Abuse Treatment Diversion (more...)

Exhibit 5-1 Juvenile AOD Abuse Treatment Diversion Program Checklist

Task 1 - Identify participants and

Task 7 - Develop selection criteria Task

key leaders Task 2 - Secure funding Task 3 - Identify lead agency Task 4 - Develop goals and objectives Task 5 - Establish interagency linkages Task 6 - Establish interagency dispute resolution guidelines	8 - Develop grievance procedures Task 9 - Establish information sharing and confidentiality guidelines Task 10 - Provide for timely access Task 11 - Establish continuum of services Task 12 - Develop accountability measures
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The following sections describe implementation steps that must be considered at each step. They are summarized in [Exhibit 5-1](#).

Identify Participants and Key Leaders

Key leaders of the components within the various systems involved in the AOD abuse treatment diversion program must be active in both planning the program and implementing it. The first step in identifying key leaders is to contact the individual and agency stakeholders identified in [Chapter 3](#). These are the persons and agencies most familiar with the various aspects of the problem (including representatives of juvenile court judges and services, parents and advocacy groups, persons with recent experience using the current system, law enforcement agencies, AOD prevention and treatment programs, community agencies, public and mental health centers, schools, business organizations, and other agencies that have contact with juveniles). Agencies can be asked to identify a contact person who has authority to commit agency resources to participate in developing the program.

The primary individuals and agencies involved in implementing a program for diverting AOD-abusing youths from juvenile court interventions are the same as those involved in planning, as described in [Chapter 3](#): 1) the juvenile judge and the juvenile court; 2) the AOD abuse treatment system; and 3) community physical and mental health and social services. The JJS can use the legal power of the court to enhance treatment by effectively influencing or motivating the youth to engage in AOD abuse treatment and holding the youth—and at times even the family -- accountable for doing so. AOD abuse treatment system players include providers in public programs, contractors operating AOD abuse treatment programs, representatives of single State

agencies (SSAs), and private programs. Community physical and mental health services and social services providers include the public health department, private practitioners, child welfare agencies, child and family services, welfare services, and homeless programs. Representatives from the public health system can include hospitals, public health units, rural cooperatives, and county and State health departments. Other participants can include neighborhood groups (neighborhood and parent associations, including business and religious communities) and the educational community.

Secure Funding

In times when funding may be limited or nonexistent, communities are going to have to address obtaining funding in creative and innovative ways. There are several scenarios for obtaining funding. One approach is to first explore funding services, design a program, and then formally request funds for it. Another way is to obtain startup funding in order to develop a program, then obtain more funding to implement the program. Another is to obtain the funding, then design and implement the program. A fourth, useful in obtaining potential funding, is to get agencies to commit part of their budgets to supporting the program. Obtaining funding is not a one-time event but a continuing activity. Different communities, agencies, and funding entities have different ways of funding programs and services. Although securing funds is second on the checklist, it is an activity that needs to go on throughout the life of the project.

Obtaining funding is not a one-time event but a continuing activity.

Funding mechanisms may include the assessment of fees from program participants, allocation of assessments or a percentage of fines imposed on AOD-related crimes, proceeds from drug forfeiture (sales of dealers' assets, handled through Federal and local law enforcement), private insurance, license fees, government and private foundation grants, private funds (for example, from the business sector), community matching funds, and untraditional resources.

Opportunities created as a result of healthcare reform, refinancing, and restructuring should also be explored. Funding issues affect treatment choices but should be driven by the specific

continuum needed. The implementation manual should provide a clear discussion of the pros and cons of resource allocation.

Identify a Lead Agency with Responsibility for Implementation

Because in most jurisdictions the juvenile court is the focal point of all agencies involved with youth in the JJS, the role of the juvenile court judge will be vital, and he or she should take an active lead in convening the stakeholders in the implementation process.

Develop Program Goals and Objectives

The intent of programs designed to divert selected AOD-abusing youth from the JJS is stated in the prospectus for this Treatment Improvement Protocol ([See Appendix H](#)): Justice systems that have interventions that provide habilitative conditions for juvenile offenders and their families can work to divert from the justice system a population of young offenders who are at risk for later committing criminal acts associated with their substance use disorder. The Juvenile Justice field has great need for such interventions with youth who are initially status offenders or who have experienced previous adjudication for lesser offenses and are at significant risk for criminal activity. . . . Effective treatment of substance use disorders among adolescents requires a comprehensive approach that incorporates family and health issues. A holistic approach to the treatment of adolescents may obviate their future involvement in status offenses or delinquent or criminal activity.

The goals and objectives for AOD diversion will vary from locale to locale, depending on such factors as State laws, local attitudes about crime and punishment, local attitudes about AOD abuse, and the availability of local AOD abuse treatment resources for juveniles. The mission statement can help unify the many organizations involved in diversion program planning and implementation.

Goals and objectives can be established, taking care that the results of program activities can be measured and evaluated. An effective program might have the following goals and objectives:

1. All youth eligible for diversion to AOD abuse treatment will be identified and appropriately placed, using screening and assessment:
 - Screening will be conducted to identify youth for whom further assessment is indicated.
 - Assessment will be conducted by a qualified assessor.
 - Screening and assessment will be available at a number of convenient locations.
 - The youth will be placed in the type of treatment program suggested by the assessment results.
2. Each youth will have a single, individualized treatment plan based on his or her needs rather than on the availability of AOD abuse treatment slots:
 - A single case manager will be assigned to each.
 - Every youth will receive appropriate AOD abuse treatment services, as well as physical health, mental health, and social services as needed.
3. Appropriate continuing care and relapse prevention will be provided to help ensure the recovery of the youth. The treatment plan will include plans for continuing care and relapse prevention.
4. The AOD abuse treatment diversion program will be evaluated and revised as suggested by the evaluation.

Establish Appropriate Linkages Between Key Agencies

Effective communication among agencies and systems is critical to the success of any diversion program and must be continuous. The implementation manual should describe how to ensure that appropriate linkages are established. Linkages may include written agreements or memoranda of understanding, as well as interagency coordination, interagency training, liaison with community organizations, and other forms.

Establish Interagency Dispute Resolution Guidelines

Conflicts can arise regarding issues, both broad (participant agency authority, responsibility, information sharing, and funding distribution) and specific (interagency disputes over eligibility criteria or modification thereof). To assist in resolving such conflicts, a dispute resolution mechanism must be devised, agreed upon by all groups involved, and documented.

For example, an interagency committee with representatives from major agencies involved in the diversion program could serve as a mediator for such disputes, with the juvenile court designated as the final arbiter on the issue of juvenile accountability. By focusing on agency understanding and response to issues having a significant impact on juveniles and families and initiating the often difficult process of debate and action, it should be possible to resolve most issues without juvenile court intervention.

Develop Selection Criteria For Diversion

As discussed in the previous chapters, the selection criteria (eligibility guidelines) for youth entering the AOD abuse treatment diversion program must be documented clearly and disseminated to all key stakeholders in the participating systems. The eligibility criteria should include the juvenile's age, educational background, and level of sophistication and maturity, as well as consideration of the nature and history of the juvenile's offending conduct, any statutes that may preclude a particular juvenile from participating in diversion, the juvenile's amenability to treatment (and amenability to sharing information within the diversion system), the nature and extent of the AOD problem, previous court contact (history), and previous AOD abuse treatment diversion experience. It may be necessary to distinguish amenability to treatment from recognition of the drug problem, since some juveniles will be in denial. Diversion should be voluntary, so there must be a willingness on the juvenile's part to be diverted and to participate in AOD abuse treatment.

The implementation manual must provide clear eligibility guidelines that will ensure, at a minimum, that the youth has an identified AOD use problem, qualifies for treatment, is not a threat to the safety of the community, can be held accountable through the means of AOD abuse treatment program participation, and will have access to appropriate treatment.

The eligibility criteria should include the juvenile's age, educational background, sophistication, and maturity level as well as consideration of the history of the juvenile's offending conduct, any statutes that may preclude a particular juvenile from participating in diversion, the juvenile's amenability to treatment, the nature and extent of the AOD abuse problem, previous court contact, and previous AOD abuse treatment diversion experience.

Develop Grievance Procedures for Youth and Families

The implementation manual should describe a grievance process specifically related to the appropriateness of eligibility determinations, the level and type of treatment provided, termination of eligibility, and other issues. Grievance procedures might include establishing an investigatory process; developing a mediation process; designating a staff person responsible for reviewing complaints, the youth's family, or guardian *ad litem* (for the particular action or proceeding) regarding treatment and eligibility (a complaint investigator); and establishing an appellate panel with representatives from participating agencies. It is also necessary that each participating agency have clearly articulated grievance and complaint procedures for internal use.

Establish Information Sharing and Confidentiality Guidelines

There must be a balance between sharing information on a "need-to-know" basis with those who make treatment decisions and with the court, which must monitor the process, while still protecting the youth's rights to confidentiality. The implementation manual should describe the methods or strategies for establishing this balance and developing information-sharing guidelines, while keeping in mind confidentiality laws, privilege laws, and ethical considerations. The manual should include a discussion of the appropriate levels of information to share. The manual also should include guidelines for informing treatment programs how to share information with the court in accordance with Federal and State confidentiality rules. These guidelines need to apply at the individual case level as well as at the systemic level.

The implementation manual should also include information regarding Federal and State confidentiality statutes and instructions on how to expand them to AOD abuse treatment providers in order to facilitate appropriate information sharing.

Court-mandated treatment plans, to be effective, must be monitored to ensure that the juvenile and family are participating as required and that the AOD abuse treatment diversion is meeting their needs. The implementation manual should provide guidelines or protocols for ensuring the consistent sharing of information in a collaborative way between AOD abuse treatment providers and the JJS. Such guidelines will assure that the juvenile court judge, individual juvenile court case managers, and other appropriate interested parties are aware of the array of information-sharing concerns affecting AOD abuse treatment of diverted juveniles.

Ensure Timely Access to Screening and Assessment

Timely access for eligible juveniles to screening and assessment is essential for effective implementation of AOD abuse treatment diversion. "Timely" in this context means at the earliest possible opportunity—during the intake process. What constitutes "timeliness" should be defined in the implementation manual and should be based on the needs of youth, the availability of AOD abuse treatment resources, and organizational constraints.

Some States have statutorily mandated time limits for court-ordered medical or mental health examinations or studies after a youth is placed in custody. Other States do not have any time constraints between custody, custody hearings, adjudication, and disposition. In those States where there are no such time limits, the implementation manual should establish guidelines to ensure that the court has access to information and that the juvenile has access to treatment as soon as possible.

The implementation manual should include a discussion of the appropriateness or usefulness of offering the youth (or parent) the opportunity to waive the right to a speedy trial. For example, in some States it is required that a juvenile in detention have the first hearing within 48 hours of detention. If the juvenile is detained in custody, the case may have to be adjudicated within 14

days. The time between the formal filing (petition) and adjudication varies; the implementation planning group should consider any requirements associated with scheduling.

A potential barrier to quick access may be the time associated with case processing in the local juvenile court. The implementation manual must address case processing concerns in the local juvenile court system and whether improvements can be made. The National Council of Juvenile Family Court Judges' Alcohol and Substance Abuse Committee (1994) recommends that courts intervene as early as possible (as early as the judicial process permits) whenever they determine that AOD abuse is an issue in a case. Therefore, screening and assessment for appropriateness of diversion to AOD abuse treatment should take place as early as possible. This process is also necessary to increase the effectiveness of treatment. Screening should take place at intake, but an exact "timeline" for assessment is impossible to determine because timing depends on when the case is going to court.

Establishing an Appropriate Continuum of Services for AOD Abuse Treatment

The implementation manual should list and describe the ideal continuum of services for the effective treatment of AOD-abusing juveniles in the community. This continuum of treatment services should be determined based on AOD abuse demographics and should cite all agencies to which referral may be made for needed healthcare or social services.

The manual should also contrast the ideal continuum with what is actually available in terms of AOD abuse treatment for youth. This contrast involves identifying the resources available from assessment through the various levels of treatment, establishing a directory of services (for example, a resource book), and establishing relationships with the programs and facilities within or closest to the planning region.

The difference between the *ideal continuum* and the *real continuum* represents the gaps in AOD abuse treatment services available to the community. In addition to describing clearly how to gain access to existing resources, the implementation manual should describe how to develop

resources to fill the gaps identified in AOD abuse treatment services. Gaps in the local AOD abuse treatment continuum may be bridged by establishing innovative relationships between providers or by tapping into AOD abuse treatment resources available in surrounding communities. As always, the goal should be to place juveniles in AOD abuse treatment as close to home as possible. It may also be necessary to reallocate funding based on the gaps identified in AOD abuse treatment services for youth.

The difference between the *ideal continuum* and the *real continuum* represents the gaps in AOD abuse treatment services available to the community. These gaps may be bridged by establishing innovative relationships between providers or by tapping into AOD abuse treatment resources available in surrounding communities.

Ensuring Accountability

To combine diversion with AOD abuse treatment successfully requires accountability on a number of levels—personal accountability on the part of the youth, system accountability on the part of the participating system components and referral agencies, and assurances of treatment integrity and effectiveness. The issue of holding youth accountable is particularly critical in an AOD abuse treatment program for youth diverted from the JJS. AOD abuse treatment must be a reasonable, active accountability approach to traditional juvenile court sanctions. It cannot be perceived (by the youth or the community) as a means of avoiding personal responsibility. Addressing system accountability ensures that the concept of combining diversion and AOD abuse treatment is a legitimate one. Effective measures of treatment outcomes will demonstrate whether the community is being served adequately by the diversion of offending youth to AOD abuse treatment.

The evaluation plan is an integral part of the diversion program, as important as the initial screening and assessment process. It must be based on outcome measures for assessing the effectiveness of system collaboration, the quality of provider services, and the impact they have on the individual juvenile in the diversion program.

The implementation manual must include a well-designed evaluation plan that addresses both process (Is the program operating as envisioned?) and outcome measures (Are we getting the results that we had anticipated?). It must be comprehensive in design, encompassing the whole system. A number of evaluation elements must be set forth unambiguously, including the type of data to be collected, evaluation models to be used, and means to be used to track the success of the juvenile over time.

The evaluation design must be sensitive to the entire diversion process. Existing data collection systems must be linked to the accountability system. The implementation manual can describe methods and strategies for accessing required information.

TIP 21: Appendix A -- Bibliography

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TIP 21: Appendix B -- Glossary

Adjudication: : A juvenile court decision, after a hearing, to uphold a petition by finding a child delinquent, a status offender, or dependent, or else to dismiss the petition and release the child.

Aftercare: : Supervision or treatment given children for a limited time after they are released from a correctional program, but still under the control of the juvenile court.

Child Abuse: : Willful causing of physical harm to a child. Frequently would bring the child under the protection of the juvenile court.

Child Neglect: : Willful failure to provide for one's child or ward adequate food, clothing, shelter, education, or supervision. Frequently would bring the child under protection of the juvenile court.

Deinstitutionalization: : Moving juveniles out of secure care facilities, detention centers, or jails and into community-based programs or into the community.

Delinquent: : A juvenile whom a judicial officer of a Juvenile court has adjudged to have committed a delinquent act.

Delinquent Act: : An act committed by a juvenile for which an adult could be prosecuted in a criminal court.

Dependency: : Legal status of juveniles over whom the court has assumed jurisdiction upon a finding that their care by parents or guardians has fallen short of proper standards.

Detention: : Holding a child in physically restrictive, secure facilities until court disposition or another court order (such as placement in a nonsecure facility while awaiting disposition).

Detention Center: : The locked ("secure") facility in which such children are detained.

Detention Hearing: : A proceeding before a judicial officer to determine whether a child is to be detained, continue to be detained, or released pending further juvenile court action.

Disposition: : The juvenile court's decision, after a petition is sustained, whether the child should be placed in a correctional facility, placed in a care or treatment program, be required to meet certain standards of conduct, or be released. A care program for a dependent child might be placement in a foster home.

Diversión: : Removing a juvenile from the formal justice system and referring the child to an agency outside the justice system for treatment or care. This step may be taken at any point in formal processing, from the initial custody to the adjudication phase.

Family Court: : A court of limited jurisdiction whose authority covers family matters such as neglect, delinquency, paternity, support, and noncriminal misbehavior.

Group Home: : Nonsecure residential facility for adjudicated juveniles intended to approximate family life and provide access to community activities.

Intake: : Process of receiving into the juvenile justice system a juvenile referred or taken into custody. At the intake stage, a decision must be made whether to file a petition in juvenile court, release the juvenile, place the juvenile under supervision, or refer to another private or governmental agency.

Juvenile Court: : A court of limited jurisdiction which holds original jurisdiction over persons defined by law as juveniles and alleged to be delinquents, status offenders, or dependent and in need of support.

Juvenile Justice and Delinquency Prevention Act of 1974: : Federal law establishing the Office of Juvenile Justice and Delinquency Prevention within the U.S. Department of Justice to provide funds for the control and prevention of juvenile delinquency. Amended in 1977, 1980, 1984, 1988, and 1992.

Parole: : Conditional release from a correctional institution, such as a training school, before the term of disposition expires, with supervision by the paroling authority.

Petition: : Document filed in juvenile court, usually by a prosecutor, asking that the court take jurisdiction over a juvenile alleged to be delinquent, a status offender, or dependent.

PINS, CHINS: : Person in need of supervision; child in need of supervision; various States use other similar designations. Juveniles found to be ungovernable, incorrigible, truant, or habitually disobedient; thus, "status offenders;" see "status offense" below.

Probation: : Conditional release of an adjudicated offender into the community, by court order and under court supervision, under specified conditions, for a set amount of time.

Residential Child Care Facility: : Dwelling other than a detention or shelter care facility that is licensed (or operated) by government to provide living accommodations, care, and treatment for children and youths. Includes foster homes, group homes, and halfway houses.

Restitution: : Compliance with a court order that an offender restore what a victim has lost through a crime or delinquency. Juveniles, ordered by the court to make restitution, may be required to pay back or repair damages to the property of their victims, or perform services to the community.

Runaway: : A juvenile whom a juvenile court has found to have committed the status offense of leaving the custody or home of parent or guardian without permission and without returning in a reasonable period of time.

Status Offense: : An act prohibited by statute, but only when committed by a juvenile, such as running away from home or truancy.

Take Into Custody: : Law officers' securing the physical custody of a juvenile alleged to be delinquent; comparable to the arrest of an adult.

Training School: : Correctional facility for juveniles committed to confinement by the juvenile court. Also called reform school.

Transfer or Waiver to Adult Court: : A juvenile court decision, after a hearing, to relinquish its jurisdiction and permit a juvenile to be tried as an adult in a criminal court. In some States, the prosecutor and not the court may decide to try juveniles for specified serious crimes in adult rather than Juvenile court. In others (e.g., New York), certain crimes are automatically tried in adult court unless that court waives the case back to juvenile court.

Appendix C—CSAT Juvenile Justice Treatment Planning Chart

The Juvenile Justice Treatment Planning Chart is a 3 1/2 foot fold-out chart suitable for display. The reverse side of the chart contains a glossary of the terms used in the chart. There was no effective way to present this chart in electronic format.

Both a hard copy of the chart printed on glossy paper and a copy of the entire TIP containing the chart can be ordered from the National Clearinghouse of Drug and Alcohol Information (NCADI). The order number for the chart by itself is PHD 598 and for the entire TIP is BKD169. The documents are free and can be ordered from NCADI's electronic catalog at <http://www.health.org/pubs/catalog/ordering.htm> or by calling 1-800-729-6686.

TIP 21: Appendix D—Oregon's Department of Human Services Multiagency Release

Authorization for Release of Information

To Our Clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

Name

D.O.B.

ID #

(Use SS# for Employment and Vocational Rehabilitation)

Children

I authorize the following individuals or agencies:

■

■

■

■

to provide information to:

(Name)

(Address)

Including records of:

___ Yes ___ No Family History

___ Other, as listed:

___ Yes ___ No Employment/Unemployment

.

___ Yes ___ No Educational Reports

.

___ Yes ___ No Alcohol/Drug Treatment

.

___ Yes ___ No Mental Health Services

.

___ Yes ___ No Medical/Psychiatric Treatment

.

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment, and prognosis. Educational records include both behavioral and progress reports.

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances. ___ Yes ___

No

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified:

.

This permission is good for one year or until: I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

___ Client ___ Guardian ___ Parent ___ Legal
Custody

Signature

Date

Worker Name

Worker
Signature

Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document (Agency Staff Person)

For People Who Cannot Write

I understand this form and am completing it voluntarily. I cannot write. I am placing my mark by my name to sign this form.

My Mark:

Full Name of Client:

Date:

Witness #1

Address:

Witness #2

Address:

For People Who Cannot Read

I have read the form to the client. He/she understands it and signed it voluntarily.

Worker's Name

Signature

Date

* Explanation: Supplying the Social Security number is voluntary, and in general the refusal to supply the Social Security number cannot be used to deny services. However, it is necessary for identifying records for Employment and Vocational Rehabilitation information. In either case, if supplied, the Social Security number may be used to enforce agency regulations.

INSTRUCTIONS

1. The worker should fill out this form for the client. Be sure the client understands it before signing. Encourage the client to ask questions about the form and what it allows.
2. Mail Requests. If this form is being used to request information by mail, be specific about what you need. If you have a series of questions, use a cover letter. The more clear you are in your request, the more likely you

are to receive a prompt and accurate response. Do not ask for information you do not need.

3. Family Records. This release covers information about the person signing the form, minor children, and information about the family he/she supplied for the record. It would not cover information supplied by other adult family members unless they also sign a release.
4. Children. Minors can consent to medical treatment at age 15, mental, emotional or chemical, depending on treatment, at age 14. They may sign their own permission for release of information forms needed for such treatment.
5. Photocopying. Keep the original in the file and send copies to other agencies. The person making the photocopies should sign each copy at the bottom of the first page certifying it as a true copy. The agency receiving the authorization should reject it if there is not an original signature by the person who made the copy.
6. Redisclosure. Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 C.F.R. Part 2) prohibit you from making any further disclosures of Alcohol and Drug information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
7. Revocation. If the person later cancels this authorization, write "revoked" and the method and date of revocation boldly across the form. Date and initial it, and keep it in the file. Federal regulations do not allow us to require that the revocation be in writing.
8. Duration. The authorization is valid for one year unless otherwise specified. Check to be sure that the release you are using is still current.

9. Guardianship/Custody. If the signer is a guardian, a copy of the guardianship paper must be attached when the request is sent. Similarly, if an agency has custody and their representative signs, the custody order should be included.
10. This is a Voluntary Form. However, clients should be given accurate information on how the refusal to allow the release of information will adversely affect eligibility determination or coordination of services. If the client decides not to sign, attempt to refer the family to a single service that may be able to help them without an exchange of information.

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TIP 21: Appendix E—Assessment Instruments for Adolescent Populations

SUMMARIES OF ASSESSMENT INSTRUMENTS FOR IDENTIFYING AND DIAGNOSING ADOLESCENT DRUG INVOLVEMENT

Prepared by Pamela J. Schaefer

American Probation and Parole Association

1992

This information was prepared by the American Probation and Parole Association under Cooperative Agreement No. 90-JN-CSA-K)5 from the Office of Juvenile Justice and Delinquency Prevention.

Point of view or opinions in this document are those of the authors and do not necessarily represent the office position or policies of the U.S. Department of Justice.

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The information in this booklet was derived from brochures and literature provided by companies marketing assessment instruments or agencies which have developed assessment instruments, and through personal communication with those companies and agencies. The information herein is not based on empirical research conducted by the American Probation and Parole Association. In addition, the inclusion of certain assessment instruments does not represent an endorsement or recommendation.

The terms below are those used by the assessment companies or agencies that developed the instruments and are thus contained in this material. The definitions are intended to make the following material more understandable to the reader. Many of these terms are complex; their complete definitions are beyond the scope of this workshop. Therefore, the definitions have been simplified to coincide with their use in this booklet.

DEFINITIONS:

Analysis of Variance: : Evaluating factors that contribute to differences in test results obtained from individuals to examine whether gender, race, religious or other differences have affected test scores.

Construct Validity: : The extent to which a test may be said to measure a theoretical trait, such as chemical dependency.

Convergent Validity: : Extent to which a test correlates highly with those variables with which it should theoretically correlate. In a substance abuse assessment, ability of test to correlate with variables associated with substance abuse.

Correlation: : A measure of the degree to which there is a relationship between variables.

Correlation coefficients range from -1 to +1, with zero indicating no relationship between variables. A positive correlation indicates that as one variable increases, the other variable also tends to increase. A negative correlation indicates that the variables are conversely related. The closer the correlation coefficient to +1, the closer the relationship. For instance, if test results have a correlation value of .88 with clinicians' diagnoses, the results of the test tend to be in agreement with the diagnoses of clinicians.

Discriminant Validity: : Extent to which a test does not correlate significantly with variables from which it should differ. In a substance abuse assessment, ability of test to accurately discriminate between those variables not associated with substance abuse.

DSMIII-R: : Diagnostic and Statistical Manual III - Revised. The standard manual used by the American Psychiatric Association that lists and describes all known mental disorders.

Empirically-based measures: : Measures derived from observation or experimentation, and so capable of proof and verification.

Face Validity: : If a test is said to have face validity, its items appear, upon informal examination, to be related to the variable(s) the test is designed to measure (e.g., drug dependency).

False Alarms: : Test results show a chemical dependency problem when no chemical dependency problem actually exists.

Field Testing: : The process of using an instrument or technique in the field to determine its value in terms of validity and reliability.

Inter-rater agreement: : Measure of the extent to which interpreters of test results are in agreement.

Internal consistency reliability: : The extent to which subsets of one test produce consistent results.

Reliability: : The extent to which a test produces consistent results regardless of extraneous factors that might influence the individual taking the test (e.g., mood at time of test, testing environment, who administers test).

Split-Half Method: : A method of determining the degree of reliability of a test by dividing the test into two comparable forms and comparing the two sets of results for consistency.

Standardized: : Test that is standardized has been adjusted to ensure uniformity in administration and interpretation across entire population of individuals it is designed to test.

Test-Retest: : A method of determining a test's reliability by re-administering and re-interpreting the test on a second occasion.

Validity: : The extent to which a test measures what it is designed to measure (e.g., an alcohol or drug problem).

- Source: Anastasi, Anne
- Psychological Testing, 4th Ed. Macmillan Publishing Co., New York. (1976).
- Complied 3/92

THE INSTRUMENTS:

MACH (with Drug Involvement Scale): International Professional Services, Inc.

ACDI (Adolescent Chemical Dependency Inventory) - Corrections Version : Risk & Needs Assessment, Inc.

PEI (Personal Experience Inventory): Western Psychological Services, Inc.

ADI (Adolescent Diagnostic Interview) - Available 7/92 : Western Psychological Services, Inc.

PESQ (Personal Experience Screening Questionnaire): Western Psychological Services, Inc.

ACHI (Assessment of Chemical Health Inventory) - Adolescent Version : Renovex Corporation

PSI (Problem Severity Index) and APSI: Penn/V.A. Center for Studies of Addiction

JASAE (Juvenile Automated Substance Abuse Evaluation): ADE, Incorporated

SASSI (Substance Abuse Subtle Screening Inventory) - Adolescent Version: The Sassi Institute

POSIT (Problem Oriented Screening Instrument for Teenagers):

AARS (Adolescent Assessment/Referral System): National Institute on Drug Abuse

SASI (Substance Abuse Screening Instrument) - Avail. 2/93: National Center for Juvenile Justice

SARA (Substance Abuse Relapse Assessment): University of South Florida and the Florida Mental Health Institute

CAI (Chemical Assessment Interview): Dallas Challenge, Dallas, Texas

AQ (Adolescent Questionnaire): Source: Rice-Licare and Delaney-McLoughlin, Cocaine Solutions, Haworth Press, Inc., New York

CASI-A (Comprehensive Addiction Severity Index for Adolescents) : Penn/V.A. Center for Studies of Addiction

Matrix: Assessment Instruments for Adolescent Populations:

MACH

Brief Description: The MACH (Minnesota Assessment of Chemical Health) is a comprehensive assessment instrument which contains an MDI (MACH Drug Involvement) Scale developed specifically for use with adolescents.

Distributed by Minnesota Assessment of Chemical Health, 9 Kings Lane, Chaska, MN 55318.

Phone: (612) 887-0332

Format: Standardized interview in computer format which can be given to a client (preferred) or self-administered - employs "branching" process (client responses determine direction of interview)

Administration Time: Takes about 30 minutes to administer - results generated immediately

Results: Immediate, computer-generated results include the following analyses:

- MDI Scale used to identify adolescent drug involvement
- MACH Summary for an Action Plan - Recency and duration are used to prioritize findings within five separate divisions
 - degree of dependency on drugs/alcohol
 - current stressors for which psychological treatment may be indicated
 - a prognostic indicator based on prior level of functioning
 - risks of future problems with alcohol/drugs for "true negatives" or risk of relapse for "true positives"
 - environmental obstacles to recovery, indicating extent of desirability in involving family or collaterals in the rehabilitation process
- MACH Assessment Matrix - Organizes data to specify the severity of problems related to alcohol or drug use in eight major life areas. Also

highlights stressors, or "enabling" and other obstacles to chemical health or recovery from a chemical dependency.

- MACH Referral Grid provides a graphic display of the referral options suggested by different combinations of problem severity and environmental obstacles to recovery.

Database: Designed to automatically store data for future use and to generate summary reports, quarterly/annual reports, and statistical analyses of data (e.g., client demographics, common problems presented, relationships between patterns of use and problems presented)

Validity/Reliability Studies: Test based on established instruments, surveys, tests and criteria. Validity substantiated with clinical, non-clinical, and juvenile justice populations. African-American and Native American populations were included in development and validation studies, and are currently using instrument. Not currently being used to any substantial degree with Hispanic and Asian populations. MACH determinations have had positive correlations with those of pairs of skilled counselors.

Languages: English and Swedish; development of Spanish version expected

Training: Manual and trial administrations adequate. Demonstration disk is available for self-training.

Cost: Average of \$5 per administration (less with increased volume). Unlimited administrations \$100 per month.

ACDI

Brief Description: Adolescent Chemical Dependency Inventory (ACDI) - Corrections Version is designed specifically for use in the juvenile justice system. The developing company suggests that the ACDI be used prior to an interview to facilitate a more "focused" interview and decision-making process. It was first marketed in 1988.

Distributed by Risk & Needs Assessment, Inc., P.O. Box 32818, Phoenix, AZ 85064-4401. Phone: (602) 234-2888

Format: Self-administered 104-item test, taken on computer or in booklet form. Written at the 6th grade reading level. Can be given individually, or to groups.

Administration Time: Usually takes about 20 minutes to complete.

Results: Results are generated immediately after administration of the test on the computer. If test is completed on computer, results are available in five minutes. If booklet form is used, the process takes a bit longer: answers are first keyed into the computer, and then results are generated from computer.

- Empirically-based measures are given on five scales:
 - - truthfulness (identifies guarded/defensive adolescents)
 - alcohol (measures frequency and magnitude of the adolescent's alcohol-related problems)
 - drugs (measures drug-related problems)
 - distress (measures anxiety and depression)
 - adjustment (measures youth's level of coping, adapting, and functioning in important life areas, such as family, school, authority figures, relationships, etc.)
- Risk Ranges (low, medium, problem, and severe problem) are calculated for each of the above five scales. Specific treatment and probation recommendations are presented
- Structured Interview, a 10-item self-report that provides information about the youth's perception and denial system.
- Significant items (a list of direct admission or important areas that provide further insight into the youth's situation)

- Space for staff recommendations (e.g., records, collateral reports, interviews, etc.)
- Truth-corrected scores (measurement error associated with untruthfulness; reflects what youth is trying to hide)

Database: Designed for storage of test data in an expanding data base for subsequent research analysis. Further, the company provides annual summaries of the agency's testing program at no extra charge and conducts ongoing research through the database.

Validity/Reliability Studies: Standardized at the state and local level, and restandardized through research annually. This includes multicultural standardization. Reliability verified. Consistent results regardless of how test is administered; within-test reliability found to be good also.

Languages: English and Spanish, but would likely comply with client's needs.

Training: Materials and phone consultations are often adequate. Individualized orientation and training provided free of charge, but no "formal" training "required."

Cost: \$5 to \$10 for all services (depending on volume of testing and participation in ongoing research).

PEI, ADI, and PESQ

Personal Experience Inventory, Adolescent Diagnostic Interview, and Personal Experience Screening Questionnaire were all specifically developed for use with adolescent populations by the Center for Adolescent Substance Abuse, University of Minnesota.

Available from Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025. Phone: (310) 478-2061. The ADI will be ready for distribution in early 1992.

PEI

Brief Description: A multiple-scale inventory that documents the onset, nature, and degree of alcohol and other drug involvement, and identifies the personal risk factors that may precipitate or maintain substance abuse. It was published in 1989.

Format: A 147-item questionnaire available in pencil-and-paper and computerized versions.

Administration Time: Requires about 45 minutes to complete. Results are scored via computer immediately after test is completed, or tests may be sent to company for interpretation (8-hour processing guarantee plus sending time).

Results: The following content is covered and scored:

- Drug use problem severity (10 scales, 94 items)
- Drug use frequency/onset (19 items)
- Personal risk factors (8 scales, 79 items)
- Environmental risk factors (4 scales, 35 items)
- Problem screens (6 screens, 31 items) - to determine possible need for further evaluation, treatment or referral in five areas (eating disorder, sexual abuse, physical abuse, family chemical dependency, suicide potential)
- Validity indices (5 scales, 70 items) - to indicate test-taking attitude, truthfulness

Database: Not available through company, but can be set up by agency

Validity/Reliability Studies: Construct validity substantiated through agreement of PEI scores with other self-report measures, diagnostic interview ratings, treatment referral recommendations, and parent reports. Validity across ethnic groups has been favorable, and continues to be researched. Internal consistency reliability estimates range from .70 to .97, across sample type.

Languages: French translations of the PEI (audio) are available. Working on a Spanish version.

Training: User qualifications are established by Western Psychological, (213) 478-2061. Training is required and available for a "very reasonable fee" for those who do not meet the qualifications. A schedule of upcoming trainings is available through Dr. Ken Winters, (612) 626-2879.

Cost: Manual - \$29.90 - \$32.50, tests \$9.60 to \$17.50 (paper-and-pencil), or \$9.60 to \$10.80 (computerized).

ADI

Brief Description: A standardized interview to assess DSMIII-R criteria for substance abuse disorders in adolescents, as well as psychosocial stressors, school and interpersonal functioning, psychological status and cognitive impairment. Will be available in the last quarter of 1992.

Format: An interviewer asks questions of adolescent, most of which require yes/no responses. May be administered on computer.

Administration Time: Takes about 45 minutes to interview an adolescent who uses both alcohol and marijuana; test administration increases with each additional drug by about 5 to 10 minutes. With computer version, interviewer keys in responses; results are scored and a report made immediately after test is completed.

Results: Evaluates youth in five areas:

- Presence or absence of a DSMII-R diagnosis of psychoactive substance use disorder (frequency, duration, quantity of use; diagnostic symptoms)
- Sociodemographic information (client/family demographics, referral source, living situation, school status, parent/sibling history of chemical dependency and mental disorders)
- Level of functioning on 9 domains, including psychological status and interpersonal functioning (e.g., involvement with peers, opposite sex relationships, school and academic functioning, use of spare time, home behavior)

- Severity of psychosocial stressors (self-image, interpersonal issues, physical and mental health, tragic/embarrassing events, home/school problems)
- Rating of memory and orientation
- Eight psychiatric status screens alerting interviewer to other difficulties often associated with substance abuse (i.e., depression, mania, eating disorder, delusional thinking, hallucinations, attention deficit disorder, anxiety disorder, and conduct disorders)

Database: Not offered by company, but can be set up by agency

Validity/Reliability Studies: Inter-rater agreement, test-retest reliability, and convergent validity on clinical diagnoses, self-report measures, and treatment referral recommendations have been established.

Languages: Work on a Spanish version is underway.

Training: User qualifications are established by Western Psychological, (213) 478-2061. Training is required and available for a "very reasonable fee" for those who do not meet the qualifications. A schedule of upcoming trainings is available through Dr. Ken Winters, (612) 626-2879.

Cost: Manual - \$23.25 - \$25.00, tests \$1.11 - \$3.50 (paper-and-pencil) and \$9.60 - \$10.80 (computerized)

PESQ

Brief Description: Self-report screening questionnaire for use with adolescents suspected of abusing alcohol or other drugs. The questionnaire was published in 1991.

Format: 40-item questionnaire, available in pencil-and-paper form, and appropriate for use with individuals and groups. Written at fourth grade reading level.

Administration Time: About ten minutes to administer and score.

Results: Routine screening useful in making referrals rather than providing an in-depth evaluation. Easily scored in five areas:

- Drug use problem severity (18 items) measures psychological and behavioral involvement with chemicals
- Drug use history (6 items) measures drug use frequency and onset
- Psychosocial risk (8 items) indicates the presence of other mental/behavioral problems, personal and environmental problems associated with substance abuse
- Defensiveness (5 items) indicates when the adolescent may be "faking-good"
- Infrequency (3 items) indicates when the adolescent may be "faking-bad" or not taking the test seriously

Database: Test is not taken or scored on a computer.

Validity/Reliability Studies: Validated on drug clinic, juvenile offender and school samples. Internal consistency reliability very high (.90-.94). Problem severity scale correlates with Personal Experience Inventory (.88) and with group status, treatment history, and diagnostic ratings.

Languages: French translations (written) are available. Work in progress on Spanish version.

Training: User qualifications are established by Western Psychological, (213) 478-2061. Training is required and available for a "very reasonable fee" for those who do not meet the qualifications. A schedule of upcoming trainings is available through Dr. Ken Winters, (612) 626-2879.

Cost: Manual \$19.90 - \$21.50; test .96 - \$1.10

ACHI

Brief Description: The Assessment of Chemical Health Inventory - Adolescent Version is designed to evaluate the nature and extent of adolescent and adult chemical use and associated problems. The test was published in 1989.

Available from the Renovex Corporation (Recovery Software, Inc., 1 Corporate Center, 7401 Metro Blvd., Suite 445, Minneapolis, MN 55439). Phone: (612) 831-5835.

Format: 128-item self-report inventory available in pencil-and-paper or computerized versions. Written at the 4th grade reading level.

Administration Time: Requires about 15 - 25 minutes to complete and another 20 minutes to score by computer on-site. Otherwise, may be sent in on ACHI Response Forms for scoring and interpretation.

Results: Provides an evaluation on ten scales, including:

- Test taking behavior (random, inattentive or inconsistent testing, defensiveness, and exaggeration)
- Significant Client Life Factors and Problem Severity Factors (depression, physical/sexual abuse, self regard, alienation, family support, family estrangement, family chemical use problems, legal problems, eating concerns, etc.).
- Overall Assessment Score in comparison to a distribution of scores of substance abusers and nonabusers
- Need for treatment
- Level of care recommendations

Database: Tests and results may be stored on computer

Validity/Reliability Studies: Discriminant validity was found to be good (test accurately discriminated between adolescents diagnosed as substance abusers and those who were not).

Analysis of variance indicated no age, sex, race, or religious differences significantly affecting the ACHI scores.

Languages: Available in English only.

Training: Self-instructing manual provided with instrument. Training not required, but available for a negotiable fee at customer location for limited number of participants if desired.

Cost: Approximately \$4.50 - \$6.00 per test

PSI and APSI

Brief Description: Pennsylvania Juvenile Court Judges' Commission Problem Severity Index was developed in 1988. It is a structured interview, developed to identify, document, and respond to drug/alcohol abuse as well as problems in other important areas of functioning among adolescents entering the juvenile court system. The instrument was designed by the University of Pennsylvania/Philadelphia VA Medical Center, Addiction Research and Treatment Center under a contract from the Wyoming County Juvenile Probation Department.

The APSI is similar to the PSI, but is designed for use in non-juvenile justice settings, such as treatment facilities, mental health agencies, or schools. It is basically the same, but does not go into detail in the legal section of the interview.

For further information on this instrument, contact Jim Boylan, Juvenile Court Judges Commission, P.O. Box 3222, Harrisburg, PA 17105. Phone: (717) 787-6910.

Format: Structured interview conducted according to PSI Guidelines

Administration Time: 45-60 minutes

Results: Each section of the test provides for the following information:

- Youth's self-assessment of the situation

- Intervention Severity Ratings (the interviewer's assessment of need for additional intervention in each area)
- Interviewer's Confidence Rating (indicating that the interviewer thinks that the youth does not understand or is misrepresenting his/her situation)
- Guardian Agreement Box (opportunity for guardian to agree/disagree with interviewer's Intervention Severity Rating for consideration before treatment planning)
- Composite Scores (objectively represented number of risk factors youth is facing in certain areas of functioning)

Sections of test include:

- General information
- Legal
- Family relationships
- Education/work
- Medical
- Psycho-social adjustment
- Drug and alcohol use
- Personal relationships (including high risk sexual behavior)
- Summary page, which includes any comments for report

Database: A program for data entry and report generating capability has been developed.

Database may be used to generate narrative and summary reports about each case, and for other analyses.

Validity/Reliability Studies: Face validity has been substantiated. Field testing has been favorable, but more sophisticated reliability/validity tests are being performed, but are not completed.

Languages: English

Training: Training can be arranged for a fee (contact Jim Boylan, address and phone number above), but ongoing support is not possible since this instrument has been designed and copyrighted by the State of Pennsylvania. It is not currently marketed to the public.

Cost: No charge for use of instrument

JASAE

Brief Description: The Juvenile Automated Substance Abuse Evaluation is a computer-assisted instrument for assessing alcohol and other drug use behavior in adolescents. Test addresses issues and attitudes unique to adolescent, and includes items that address society's values and beliefs. Suggested for use with follow-up interview to provide focus and conserve amount of time necessary to conduct interview. The JASAE was first made available in 1989.

Available through ADE, Incorporated, P.O. Box 660, Clarkston, MI 48347. Phone: 1-800-334-1918.

Format: 102-item self-administered questionnaire, can be given to individuals or groups. It is written at the 5th grade level. Tests are available on audiotape in both English and Spanish for those who cannot read. It is a computer-assisted instrument, meaning the juvenile completes a pencil-and-paper questionnaire, then personnel key the responses into the computer.

Administration Time: Takes approximately 20 minutes to complete, and about 5 minutes to key in responses and receive the printed evaluation. In high volume agencies, an optical scanner may be used which can score each test in about 5 seconds.

Results: Addresses and/or assesses the following areas:

- test taking attitude (6 levels which indicate different attitudes toward self, the test, and the way one wants to portray self)
- Life circumstances (4 levels of stress portrayed, areas of stress listed)
- Drinking behavior (5 levels of severity of a drinking problem indicated)

- Drug use behavior (5 levels of severity of a drug problem indicated)
- Recommended interventions (presents a broad focus of intervention, such as education or some type of treatment, and an individualized referral to increase the chances of achieving the intervention goal)
- Summary score - places individual in categories indicating severity of problem and level of intervention required
- Important symptoms - list of important respondent answers that provide valuable information for clarification of treatment needs and further evaluation
- Demographics - provides overview of demographic information
- Recent blood alcohol content analysis and driving record
- Results are based on patterns of responses, not individual responses.

Database: A database diskette for running statistical analyses on data collected may be obtained upon request.

Validity/Reliability Studies: ADE conducts ongoing evaluative research on the JASAE through programs developed by those who are using the JASAE. Validity measured through a comparison between results of the JASAE and personal interviews by professional substance abuse counselors and assessors. 85% agreement was found. Reliability was evaluated through test-retest method, and .93 level of correlation was found. Measured through the split-half method, a .91 level of correlation was indicated.

Languages: English and Spanish versions available

Training: Customers are able to initiate use of the instrument through the reference guides that come with it, and telephone assistance offered by the company. Continued support and training is provided through an 800 number. Once the customer has piloted the instrument, on-site training is available free of charge to those who find it necessary or desirable. Upgrades of the test are furnished free of charge to all customers. Annual "refresher" training courses are also available free of charge.

Cost: No start-up or administrative fees. \$6 to \$8 per evaluation, depending on volume used.

SASSI

Brief Description: The Substance Abuse Subtle Screening Inventory - Adolescent Version is a self-administered questionnaire, designed to be resistant to "faking." It was first marketed in June of 1990.

Available through the SASSI Institute, 4403 Trailridge Road, Bloomington, IN 47408. Phone: 1-800-726-0526.

Format: 52 true-false questions that appear to be unrelated to substance abuse. 26 items that allow clients to self-report negative consequences of their use of alcohol and other drugs. May be administered in booklet or computer form. Can be given to individuals or groups. It is written at approximately the third grade level.

Administration Time: Requires 10-15 minutes to complete, and about one minute to score.

Results: Evaluates adolescent on 6 scales:

- OAT (obvious attributes to chemical dependency, alcohol and/or drugs)
- SAT (subtle attributes to chemical dependency, alcohol and/or drugs)
- DEF (measure of defensiveness/can also measure suicidal tendencies)
- DEF2 (indicates highly defensive/chemically dependent)
- COR (measures similarity to adolescents in correctional settings, an "acting out" measure)
- RAP (indicates whether individual is taking the test seriously or meaningfully)

Ends with decision rules: Should juvenile be judged chemically dependent? Decision rules for optimal treatment selection are also available.

Database: Information may be stored in computer. Summaries and analysis possible as well.

Validity/Reliability Studies: Able to assess chemically dependent or not in over 90% of cases. Only 2% to 10% "false alarms".

Language: Currently available in English only, with Spanish version being developed

Training: May use Manual to administer instrument without training. May also request additional training to enable further understanding of ways to use the instrument for free or reasonable charge, depending on format. Certification available for those who go through training. Free consultation always available for those who purchase the Manual.

Cost: Starter kit, which includes manual, scoring key, sample scored tests, and 25 tests and profiles is \$75. Purchased separated, manuals are \$55 each; scoring keys \$10 each. Tests cost less than \$2.00 each once start-up material is purchased.

AARS

This is not a diagnostic tool in itself, but a guide for assessment of youth. It begins with an initial screening in multiple areas (POSIT), and branches off to more in-depth evaluations if needed (diagnostic tools used at discretion of agency, though recommendations are made).

Interventions are also at the discretion of the agency, based on resources determined to be available to them.

Description: The Adolescent Assessment/Referral System was developed for the National Institute on Drug Abuse (NIDA) by Westover Consultants, Washington, D.C., and the Pacific Institute for Research and Evaluation, Bethesda, MD. It consists of the POSIT (Problem Oriented Screening Instrument for Teenagers) which is designed to screen for multiple problems affecting a child's life that are typically associated with a youth's drug/alcohol use. The second step in the process is a more in-depth assessment into each problem area identified through the POSIT. The third component is a guide for treatment matching -- the correlating of diagnostic profiles with different therapeutic programs -- in the form of available treatment, rehabilitation, and education directories.

For further information, contact: NIDA, Division of Clinical Research, 5600 Fishers Lane, Room 10A-30, Rockville, MD 20857. Phone: (301) 443-4060.

Components included in the AARS Manual are:

- Problem Oriented Screening Instrument for Teenagers (POSIT) - to screen for multiple problems in ten different areas of functioning:
 - - substance use/abuse
 - physical health status
 - mental health status
 - family relations
 - peer relations
 - educational status
 - vocational status
 - social skills
 - leisure and recreation
 - aggressive behavior and delinquency
- Personal History Questionnaire (PHQ) - to gather all necessary background information
- Comprehensive Assessment Battery (CAB) - composed of information about state-of-the-art assessment instruments and procedures.
- Physician Report Form - to be completed by juvenile and doctor when a possible physical problem is flagged
- Physical Activity Assessment - to be completed by adolescent if a problem is suspected in the leisure and activity area
- National Youth Survey Delinquency Scale - to be completed through interview with adolescent if aggressive behavior/delinquency is flagged as possible problem area

- Guide to the development of a Directory of Adolescent Services to identify, evaluate, and catalogue existing local or regional treatment and rehabilitative services for troubled adolescents.

Format: The POSIT is a 139-item questionnaire that screens for problems in ten different areas (see above). Available in pencil-and-paper form, English and Spanish versions. Can be administered individually or to groups. Scoring templates and sheets included.

The PHQ consists of approximately 75 questions about the juvenile's personal history and currently status. Pencil-and-paper version available in English and Spanish, can be administered individually or to groups.

The Physician Report Form is a 9-page in-depth medical report to be completed by the youth and the doctor. Takes about 30 minutes. In English only.

The Physical Activity Assessment is a one-page questionnaire that indicates the amount of physical activity the juvenile engaged in during the past year. About 15 minutes to complete. In English only.

The National Youth Survey Delinquency Scale is a four-page matrix of information about the youth's delinquency history. Takes 15-20 minutes to administer. Comes with scoring sheet for five scales (total delinquency, general theft, crimes against person, index offenses, and drug sales). In English only.

Administration Time: Varies with each screening tool. See "Format."

Results: Varies with each screening tool. See "Format."

Database: No computer versions available on general screening instruments.

Validity/Reliability Studies: Have not been completed on the AARS itself, nor the components presented in the AARS Manual, though trials have indicated success and no problems have been

reported. Selection of additional instruments is usually necessary and these will have separate validity/reliability reports.

Languages: Varies with each screening tool. See "Format."

Training: Manual designed to be sufficient. Additional training not necessary.

Cost: None for AARS system Manual, which includes screening instruments and scoring sheets. These can be duplicated. Cost depends on instruments selected for more in-depth evaluation.

SASI (availability pending)

Brief Description: The Substance Abuse Screening Instrument is a "short" form questionnaire appropriate for screening juveniles at intake — as they enter the juvenile justice system. Developed by a task force of nationally recognized experts for the purpose of early identification of drug involvement. The form was derived from the Client Substance Index, developed by David Moore, and used in Washington and Oregon for evaluating chemically dependent youth. The instrument is intended to be a first "gate" in a system for assessing youth. It should be used only to decide whether further evaluation is appropriate.

Availability pending from the National Center for Juvenile Justice, 701 Forbes Avenue, Pittsburgh, PA 15219-4783. (412) 227-6950.

Format: 15 self-report questions, pencil-and-paper form. May be read to youth if necessary. Brief comments as to the youth's behavior and how it relates to the screening process (e.g., hostile, cooperative, defensive) are written by the assessor.

Administration Time: About five minutes

Results: About five minutes (time for assessor to write brief comments and add up yes's and no's).

Database: No information in literature regarding this

Validity/Reliability Studies: About 80% concordance with results of the Personal Experience Inventory (PEI). Studies are continuing.

Languages: English

Training: Step-by-step manual with instrument.

Cost: Instrument development/validity studies still underway. Contact NCJJ for more information.

SARA

Brief Description: The Substance Abuse Relapse Assessment is a structured interview developed for use by substance abuse treatment professionals to help recovering individuals recognize signs of and avoid relapse. It is used mostly with adult populations but has been used with younger populations, and may be adapted for use with youth.

For further information on the instrument, contact Roger Peters, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899. Phone: (813) 974-4510.

Format: 41 questions, many of which are in-depth, administered by assessor to the youth in pencil and paper format.

Administration Time: Approximately 60 minutes

Results: Interpreted individually by assessor with input from youth

Database: Not designed for storage of information in computer, but may be set up by agency

Validity/Reliability Studies: Results have been favorable in numerous field tests.

Languages: English

Training: No formal training available. Some expertise in assessments is required to interpret the results of the interview. Agencies may contact Roger Peters (address above) for guidance in using the instrument.

Cost: No charge

CAI

Brief Description: The Chemical Assessment Instrument was developed by Dallas Challenge, Dallas, Texas, a substance abuse treatment agency.

Format: Standardized interview to be administered by staffperson to youth. Pencil and paper format.

Administration Time: Approximately 60 minutes

Results: Information obtained in eight key areas:

- Personal
- School history with current status
- Work experience
- Social history
- Psychological problems
- Drug use history
- Family systems and relationships
- Legal status/dispositional behavior

Database: Not designed for storage of data but may be set up by agency

Validity/Reliability Studies: Instrument has had favorable results in field tests.

Languages: English

Training: No formal training on the instrument itself is required. Should be administered and interpreted by someone who has some level of expertise in assessment.

Cost: No charge

The AQ

Brief Description: The Adolescent Questionnaire is a screening tool for teenagers to determine whether they have a problem with cocaine.

Source: Licare-Rice and Delaney-McLoughlin (1990), Cocaine Solutions, Haworth Press, New York.

Format: A self-administered questionnaire of 20 yes-no items.

Administration Time: About 5 minutes

Results: Results are available immediately. Makes a quick determination as to whether or not the youth has a cocaine problem.

Database: May be set up by agency.

Validity/Reliability Studies: Information not available in literature

Languages: English

Training: No training necessary

Cost: No charge

CASI-A

Brief Description: The Comprehensive Addiction Severity Index for Adolescents was designed to evaluate drug and alcohol use and psychosocial severity in adolescent populations in a variety of settings. The instrument became available for use in 1991.

For further information on the instrument, contact Kathleen Meyers, Penn/V.A. Center for Studies of Addiction, 3900 Chestnut Street, Philadelphia, PA 19104. Phone: (215) 823-6098. Computer program to complement the instrument is available for a fee from Biometrics & Computing, 9743 Redd Rambler Place, Philadelphia, PA 19115.

Format: Structured interview, administered by assessor to the youth in pencil and paper format. May not be self-administered or given to groups.

Administration Time: Approximately 45-60 minutes, depending on level of drug involvement of individual being assessed. Computerized scoring technique takes about 45 minutes to enter, 10 minutes to score. Computerized version sets up database as information is entered. Individual reports and agency summaries can be obtained from the same program. The computer program is available for a fee from Biometrics and Computing (see above). A Manual for hand-scoring is being developed also. Manual scoring is appropriate only for very small agencies as it takes about three hours to score in this fashion.

Results: In addition to demographic information and life stressors, youth are evaluated in seven specific areas of functioning, with subscales in each area: education, alcohol/drug use, use of free time, peer relationships, family relationships, legal, and psychiatric status

Database: Computerized version sets up database for entry and retrieval of individual or collective summary information.

Validity/Reliability Studies: Preliminary results have been favorable. Feedback from those testing the instrument in the field have been positive.

Languages: English

Training: 1-1/2 day introductory training session offered by Penn/V.A. Center for Studies of Addiction is recommended to familiarize the user with the test. Experience with adolescents and interviewing techniques is important for successful use of the instrument. Guidance and ongoing support is provided by Penn/V.A. Center for Studies of Addiction. If the computerized version is purchased, Biometrics & Computing offers technical support.

Cost: No charge for instrument. Computerized version involves an initial fee for unlimited use.

TIP 21: Appendix F—*Desktop Guide to Good Juvenile Probation Practice (Legal Rights of Juvenile Offenders)*

B. Legal Rights of Juvenile Offenders

Major Supreme Court Decisions

Transfer to criminal (adult) court; representation by attorney; access to juvenile records

Kent v. United States 383 U.S. 541, 86 S.Ct. 1045, 16 L.Ed.84 (1966)

Morris Kent had his first contact with the juvenile court in 1959 at age 15 and was on probation to the District of Columbia Juvenile Court in September of 1961. On September 2, 1961, in a D.C. residence, there was a breaking and entering, theft and rape. Latent prints were found at the scene of the crime and a search of records revealed that the prints matched those of Kent. On September 5, 1961 he was taken into custody by the police and interrogated. He was 16 at the time. Kent was questioned for several hours, then taken to the Receiving Home for Children. The next morning the police picked him up again and interrogated him until 5 p.m. His parents did not find out about the custody until September 6th and an attorney was hired at 2 p.m. on that day. The attorney gave notice that the proposed transfer of the case to criminal court would be opposed, hired a psychiatrist, and made a formal request for Kent's juvenile records. The

juvenile court made no ruling on the attorney's motions and held a court hearing. Apparently, some of Kent's records were examined and Kent was transferred to adult court. There were no findings recorded with the transfer. Subsequently in adult court, Kent was convicted of all charges.

With the decision in this case, the U.S. Supreme Court reversed a sixty-seven year practice of what has been characterized as the "hands off" period of the juvenile justice system. From 1899, when the first statewide juvenile court system was enacted in Illinois for Cook County, until the Kent decision, the court system, which was designed to rehabilitate rather than punish, had no guidance from the highest court. The Kent case was the first look taken by the Court at the system as it was functioning, and the Court did not like what it saw. After discussing the objectives of the juvenile court system and comparing the juvenile and adult systems, Justice Fortas writing for the majority, stated: There is evidence, in fact, that there may be grounds for concern that the child receives the worst of both worlds; that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children.

The Court, in declaring that the transfer of Kent to the adult court system was invalid, dealt with four major problems with the procedure followed by the juvenile court: lack of a hearing, lack of effective assistance of counsel, access to records, and lack of a statement of reasons for the transfer. Considering that a transfer from juvenile to criminal court is critically important, it was determined that the juvenile court had exclusive jurisdiction to consider this matter, and that it must be guided by the essentials of due process and fair play. A meaningful review of the proposed transfer must include a full investigation, not merely assumptions as the basis for transfer. In line with this, an attorney representing the child was considered vital, the Court stating that the juvenile court judge had no justification for failing to rule on the attorney's motions. Further, attorney access to records of the child was essential, particularly since the Court referred to them in making its transfer decision.

Even with these objections, the decision by the Court was very close; five justices voted that the transfer was invalid, but four voted to sustain the transfer. One possible reason for this was the fact that by the time the Court considered the matter, Kent was 21 years old and out of the

jurisdiction of the juvenile court, and his conviction would be vacated, freeing Kent.

Nevertheless, legality prevailed over the informality of juvenile justice, as administered in this case.

Adjudication hearing: notice of charges; right to counsel; rights of confrontation at hearing

In re Gault 387 U.S. 1, 87 S.Ct. 1428, 18 L.Ed. 527 (1967)

The following year, the Supreme Court decided a more significant case arising out of Arizona. On June 8, 1964, when Gerald Frances Gault was 15 years old, he was arrested and taken to Children's Detention Home in Gila County, Arizona, on the basis of a verbal complaint from a female neighbor alleging Gault made an indecent telephone call. Upon his being taken into custody, no notice was given to his parents, who found out later that he was in the detention facility. The next day, the juvenile court held a hearing using a petition filed and signed by the probation officer alleging only that Gault needed the protection of the juvenile court. There was no notice to the parents, and they were not furnished with a copy of the petition. Gault was not given a copy of the petition. There was no lawyer present representing Gault and no testimony from the neighbor, who was not even present; the only testimony was that of the juvenile probation officer who had one telephone conversation with the neighbor. There was no record of the proceedings. Gault was questioned and responded, although recollections of this testimony varied. At the end of the hearing, Gault was returned to the detention facility. He was released to his parents June 11th or 12th, although no reason was given as to why he was kept in detention or why he was released. Another hearing was held June 15th. Still there was no lawyer for Gault, no complainant present, and no record. At the end of this hearing, Gault was found to be delinquent and was committed to the State Training School until age 21, unless earlier released. In Arizona at that time, no appeal was permitted in juvenile cases.

Again, the Court determined that in three specific areas the juvenile court failed to provide the child with the essentials of due process and fair play required in the Kent case. The first of these areas related to notice of charges. Despite the fact that the juvenile court judge stated that Mrs. Gault knew what the charges were and that the parents attended two hearings without objection,

the Supreme Court stated that this was not sufficient for "due process." Notice must be given, in writing, sufficiently in advance of the hearing to permit the child and his parents to be prepared. Also, the notice must state what the charges are, with sufficient particularity, so that they know what is being charged and what conduct is alleged to have taken place. The second of these areas related to the right to counsel. To the argument that the parents and the probation officer could be relied upon to protect the child's interests, it was pointed out that neither might have legal knowledge. It was also pointed out that both the probation officer, who is required to be a court officer, and the parents, who might have their own defense, may not be able to represent the child and the child only. In any situation in which a child's liberty might be affected by commitment to an institution, "due process" requires that they be notified of the child's right to be represented by an attorney, either hired by him or appointed by the court. Finally, it was determined that there are certain other rights which are so basic to a fair hearing that they should be extended to juvenile proceedings, such as the right to confront those accusing one of improper conduct, the right to avoid self-incrimination, and the right to cross-examine any witness who appears in a matter against a child.

These and other "due process" rights were familiar to the adult criminal system; however, this was the first time they were transposed to the juvenile system. Again, the U.S. Supreme Court was very close to deciding the other way, with four justices out of nine dissenting. The concern of these four was best expressed by Justice Harlan who wrote: [I]t should not be forgotten that juvenile crime and juvenile courts are both now under earnest study throughout the country. I very much fear that this Court, by imposing these rigid procedural requirements, may inadvertently have served to discourage these efforts to find more satisfactory solutions for the problems of juvenile crime, and may hamper enlightened development of the systems of juvenile courts.

Note that the Gault case is limited to the adjudication hearing and some pre-adjudication procedures. It specifically states that none of the "due process" or "fundamental fairness" standards are made applicable to the disposition phase. Concerns about the inability to tailor treatment of the individual child are not affected. In the determination of whether or not the

facts alleged in the complaint are true, the test is fundamental fairness and is to be applied objectively. Once that determination is made, evaluation and disposition still remains subject to the doctrine of *parens patriae* and is to be applied subjectively, so that each child is dealt with individually.

Standard of proof: beyond a reasonable doubt

In re Winship 397 U.S. 358, 90 S.Ct. 1068, 25 L.Ed.2d 368 (1970)

This case was initially decided one year after *Gault*. A 12 year old allegedly stole \$112 from a pocketbook in New York in 1967. At that time, New York required the same standard of proof in juvenile proceedings as in civil cases: proof by a preponderance of the evidence. Preponderance of the evidence means more than fifty percent of the evidence. Obviously, there could be decisions made by preponderance that would be very close. In criminal cases, proof is required to be beyond a reasonable doubt. This means that the evidence, taken as a whole, tends to exclude every other reasonable explanation, except as charged, with moral certainty. This case presented the question of which standard of proof would be required in juvenile court; or to put it in the terminology of the court, whether proof beyond a reasonable doubt is among the essentials of due process and fair treatment required during the adjudicatory stage when a juvenile is charged with an act which would constitute a crime if committed by an adult. The Supreme Court held that proof beyond a reasonable doubt was required.

Again, the Supreme Court applied constitutional due process standards and required the juvenile court to conform. Three Justices dissented, stating that it is not the purpose of the court to make the juvenile system a mini-criminal court.

No right to trial by jury

McKeiver v. Pennsylvania 403 U.S. 528, 91 S.Ct. 1976, 29 L.Ed.2d 647 (1971)

In this case, Joseph McKeiver, 16, was charged in juvenile court with delinquency based on conduct amounting to robbery, larceny and receiving stolen property. Through his attorney, he requested a jury trial in juvenile court, and properly preserved this request for consideration by the high court. His request was denied, and another Pennsylvania case and several North Carolina cases also involving jury requests were consolidated for hearing by the Supreme Court. In ruling that a jury is not constitutionally required in juvenile court, the Court seemed to be seeking some middle ground between the adult and juvenile systems. It was specifically stated in this case that all adult criminal rights are not being imposed on the juvenile system. Because it was believed that judges could determine the facts as well as a jury, the Court refused to impose more substantial changes in juvenile court procedure.

Double jeopardy: juvenile adjudication equated to criminal conviction

Breed v. Jones 421 U.S. 519, 95 S.Ct. 1779, 44 L.Ed.2d 346 (1975)

At age 17, Jones committed robbery with a deadly weapon in Los Angeles, California. He was detained the next day. In due course, the juvenile court held a hearing and adjudicated him delinquent. After adjudication, but before disposition, the juvenile court found him to be unamenable to treatment in the juvenile system. He was, therefore, transferred to adult criminal court, where he was found guilty of robbery and sentenced to the penitentiary. The conviction was challenged on the ground of double jeopardy.

Jeopardy denotes risk, typically associated with criminal prosecution. Double jeopardy has generally been defined as being put at risk of the same peril twice. To be tried in state **criminal** court for an action, then subjected to state **civil** court for the same action is not double jeopardy because the risk is not the same. Similarly, to be tried in state criminal court for an act is not generally a bar to being tried in federal court for the same act, as state and federal laws are separate and distinct. The Supreme Court decided that this case violated double jeopardy provisions of the Constitution when it pointed out that jeopardy attached when the juvenile court started hearing evidence on the delinquency petition. After that point, a criminal prosecution based on the same act would be double jeopardy. In addition, the Supreme Court concluded that

for the purposes of the fifth amendment prohibition against double jeopardy, "in terms of potential consequences, there is little to distinguish an adjudicatory hearing such as was held in this case from a traditional criminal proceeding" (421 U.S. at 531).

Consider how strongly the U.S. Supreme Court felt about this issue: the opinion was 9-0. There was no dissent. Further, Jones, like Gault, was 21 at the time the Court considered the case. The Court recognized that vacating the judgment set him free, because he was beyond the jurisdiction of the juvenile court.

No double jeopardy: de novo hearing or supplemental findings by judge after trial before a master

Swisher v. Brady 438 U.S. 204, 98 S.Ct. 2699, 57 L.Ed.2d 705 (1978)

This case grew out of delinquency cases heard by masters in Maryland in 1974 and 1975. Children whose cases were tried before masters objected to the state procedure for providing for de novo, or new, hearings before the juvenile court judge, or supplemental findings to those of the master by the juvenile court judge. The objections were based solely on the grounds of double jeopardy. Refer to the discussion of the previous case about this term.

Perhaps because of the usefulness of masters and the increasing caseloads of judges, this procedure was found not to violate due process and fundamental fairness standards discussed earlier. The Supreme Court said that to the extent that the juvenile court judge makes supplemental findings in a manner permitted by Rule 911—either *sua sponte*, in response to the State's exceptions or in response to the juvenile's exceptions, and either on the record or in a record supplemented by evidence to which the parties raise no objection -- he/she does so without violating the constraints of the Double Jeopardy Clause of the U.S. Constitution.

Presence of probation officer not required for continuation of police interrogation

Fare v. Michael C. 442 U.S. 707, 99 S.Ct. 2560, 61 L.Ed.2d 197 (1979)

Sixteen year old Michael C. was implicated in the murder of Robert Yeager during a robbery. Police in Van Nuys, California picked him up on February 4, 1976 and questioned him. Before any questions, he was told his full Miranda rights. Before the questioning started, Michael asked for, not a lawyer, but his juvenile probation officer. The probation officer was not called, and the police continued to question Michael. During the questioning, Michael incriminated himself, and this incrimination was later used in the adjudication. The question raised by this case is whether asking for a probation officer is the same as asking for a lawyer, so that questioning cannot continue.

In another 5-4 decision, the Supreme Court ruled that the request did not require the police to stop the interrogation. While the juvenile probation officer did hold a position of trust with the child being questioned, he was not in a position to offer effective legal advice like a lawyer. The dissenting opinions take the position that when a child being interrogated by the police asks for an adult who is obligated to protect his interests, he is invoking the protection promised in *Miranda v. Arizona*.

Preventive pre-trial detention of juveniles; "fundamental fairness" standard of due process clause

Schall v. Martin 467 U.S. 253, 104 S.Ct. 2403, 81 L.Ed.2d 207 (1984)

Gregory Martin was arrested in 1977 and charged with first-degree robbery, second-degree assault and criminal possession of a weapon based on an incident in which he, with two others, allegedly hit a youth on the head with a loaded gun and stole his jacket and sneakers. Because he lied to the police about where and with whom he lived, he was detained overnight.

The family court judge, based on the possession of the loaded weapon, the false address given to the police and the lateness of the hour ordered Martin into preventive pre-trial detention. While he was still in preventive detention pending his fact-finding hearing, Martin instituted a *habeas corpus* class action on behalf of "those persons who are, or during the pendency of this action, will be preventively detained" pursuant to the New York Family Court Act section under which he was detained. The class action sought a declaratory judgment that the statute violated

the Due Process and Equal Protection Clauses of the Fourteenth Amendment of the U.S. Constitution. The New York district court certified the class action. On the basis of the evidence presented, the district court rejected the equal protection challenge, but agreed that pre-trial detention under the Family Court Act violated due process. The New York Court of Appeals affirmed.

The statute in question in this case permitted a brief pre-trial detention based on a finding of a "serious risk" that an arrested juvenile may commit a crime before his return date. The U.S. Supreme Court addressed two issues:

1. Does preventive detention under the New York statute serve a legitimate state objective?
2. Are the procedural safeguards contained in New York's Family Court Act adequate to authorize the pre-trial detention of at least some juveniles charged with crimes?

As to the first issue, the Supreme Court decided that society has a legitimate interest in protecting a juvenile from the consequences of his criminal activity. It also noted that, at the time of its decision (1984), every state as well as the District of Columbia permitted preventive detention of juveniles accused of crime.

As to the second issue, the Court stated that "due process requires that a pre-trial detainee not be punished." The Court found several procedural safeguards in the New York statute:

- there was no indication in the statute itself that preventive detention is used or intended as a punishment;
- the detention was strictly limited in time;
- detained juveniles are entitled to an expedited fact-finding hearing; and
- the conditions of confinement appeared to reflect the regulatory purposes relied upon by the State.

In deciding the second issue, the Supreme Court held that New York's Family Court Act provides far more pre-trial detention protection for juveniles than constitutionally required for a probable cause determination for adults. Notice, a hearing, and a statement of facts and reasons are to be given prior to any detention under the statute. A formal probable cause hearing is held within a short while thereafter, if the fact-finding hearing is not scheduled within three days.

Given the regulatory purpose for the detention and the procedural protections that preceded its imposition, the Court concluded that the New York statute permitting preventive pre-trial detention for a juvenile is valid under the Due Process Clause of the Fourteenth Amendment.

A three member dissent argued that the Court should strike down New York's preventive detention statute on two grounds: first, because the preventive detention of juveniles constitutes poor public policy, with the balance of harm outweighing any positive benefits either to society or to the juveniles themselves, and, second, because the statute could have been better drafted to improve the quality of the decision making process.

Death penalty; juveniles under 16; cruel and unusual punishment

Thompson v. Oklahoma 487 U.S.—, 101 L.Ed.2d 702, 108 S.Ct. 2687 (1988)

William Wayne Thompson, age 15, along with three older persons, actively participated in the brutal murder of his former brother-in-law in the early morning hours of January 23, 1983. After a hearing, the court concluded "that there are virtually no reasonable prospects for rehabilitation of William Wayne Thompson within the juvenile system and that he should be held accountable for his acts as if he were an adult and should be certified to stand trial as an adult." At the penalty phase of the trial, the prosecutor asked the jury to find two aggravating circumstances: that the murder was especially heinous, atrocious, or cruel; and that there was a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society. The jury found the first, but not the second, and fixed Thompson's punishment at death. The U.S. Supreme Court agreed to consider whether the execution of the death sentence would

violate the constitutional prohibition against the infliction of "cruel and unusual punishments" because Thompson was only 15 years old at the time of his offense.

The Court decided that contemporary standards of decency confirm their judgment that such a young person is not capable of acting with the degree of culpability that can justify the death penalty. In order to reach its conclusion, the court first reviewed relevant legislative enactments. The Court found complete or near unanimity among all fifty-one jurisdictions in treating a person under 16 as a minor for several important purposes: voting, serving on a jury, driving without parental consent and marrying without parental consent. In those states that have legislated on the subject, no one under age 16 may purchase pornography and in most states that have some form of legalized gambling, minors are not permitted to participate without parental consent. The Court found it most relevant that all states have enacted legislation extending juvenile court jurisdiction to no less than the 16th birthday. Of the 18 states that have expressly established a minimum age in their death-penalty statutes, the Court found that all of them require that the defendant have attained at least the age of 16 at the time of the capital offense.

The second factor the Court examined in determining the acceptability of capital punishment to the American public is the behavior of juries. The Court found that during the past four decades, in which thousands of juries have tried murder cases, the imposition of the death penalty on a 15-year-old offender was abhorrent to the conscience of the community.

In deciding whether it would be "cruel and unusual" to execute William Wayne Thompson, in particular, the Court came to several conclusions. The reasons why juveniles are not trusted with the privileges and responsibilities of an adult also explain why their irresponsible conduct is not as morally reprehensible as that of an adult. The death penalty is said to serve two principal social purposes: retribution and deterrence of capital crimes by prospective offenders. The court decided neither of these purposes would be fulfilled by executing a 15-year-old. Given the lesser culpability of the juvenile offender, the teenager's capacity of growth and society's fiduciary obligations to its children, retribution is simply inapplicable to the execution of a 15-year-old offender. As for the deterrence rationale, the likelihood that the teenage offender has made the

kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be nonexistent.

The court was asked to "draw a line" that would prohibit the execution of any person who was under the age of 18 at the time of the offense, and refused to do it. It did, however, conclude that the Eighth and Fourteenth Amendments prohibit the execution of a person who was under 16 years of age at the time of his or her offense.

Four justices joined in this plurality opinion. One justice concurred in the judgment. Three justices dissented. The concurrence concluded that Thompson and others who were below the age of 16 at the time of their offense may not be executed under the authority of a capital punishment statute that specifies no minimum age at which the commission of a capital crime can lead to the offender's execution. The dissent argued that there is no rational basis for discerning that no one so much as a day under 16 can ever be mature and morally responsible to deserve the death penalty.

Death penalty; juveniles 16 or 17; not cruel and unusual punishment

Stanford v. Kentucky 492 U.S.—, 106 L.Ed.2d 306, 109 S.Ct. 2969 (1989)

This decision was rendered on consideration of two consolidated cases. In the first case, Kevin Stanford and an accomplice repeatedly raped and sodomized a female gas station attendant during and after their commission of a robbery at the gas station. They then drove her to a secluded area, where Stanford shot her point-blank in the face and then in the back of her head. Stanford committed this murder when he was approximately 17 years and 4 months of age. Stanford was waived to criminal court where he was convicted of murder, first-degree sodomy, first-degree robbery and receiving stolen property. He was sentenced to death and 45 years in prison.

In the second case, Heath Wilkins, of Missouri, stabbed to death a 26-year-old mother of two who was working behind the sales counter of convenience store. The record reflects that Wilkins'

plan was to rob the store and murder "whoever was behind the counter" because "a dead person can't talk." Wilkins was approximately 16 years and 6 months of age when he committed this murder. He was waived to criminal court where he was convicted of first-degree murder, armed criminal action and carrying a concealed weapon. A punishment hearing was held, at which both the State and Wilkins himself urged imposition of the death sentence. The trial court determined that the death penalty was appropriate.

The U.S. Supreme Court discerned neither a historical nor a modern societal consensus forbidding the imposition of capital punishment on any person who murders at 16 or 17 years of age. They concluded that such punishment does not offend the Eighth Amendment's prohibition against cruel and unusual punishment. Therefore, it affirmed the judgments of the State Supreme Courts. A concurring opinion concluded that the death sentences should not be set aside because it is sufficiently clear that no national consensus forbids imposing capital punishment on 16-or 17-year old murderers.

Four justices joined in a dissent, stating they believed that to take the life of a person as punishment for a crime committed when below the age of 18 is cruel and unusual and thus prohibited by the Eighth Amendment. The dissent concluded that the death penalty for those under 18 makes no measurable contribution to the acceptable goals of punishment. It argued that the execution of juvenile offenders contributes neither to the goal of deterrence nor retribution, essential for the same reasons given in *Thompson v. Oklahoma*.

Probation Caselaw: Setting Conditions and Probation Revocations

Probationary Conditions

One of the most important tasks of the juvenile probation officer is to assist the court in fashioning just and effective dispositions. Properly crafted conditions of probation may safely control the behavior of even the most serious juvenile delinquents before the court. Poorly thought out and fashioned conditions may actually undermine the potential of probation to keep the juvenile out of further trouble. Probationary conditions are the building blocks of a

probationary program. Specific conditions are what make the probation fit the individual and what he has done. They detail what the probationer must do to make up for the delinquent acts and to improve behavior, while at the same time guaranteeing the public safety. For these reasons, it is important that all juvenile probation officers understand the basic premises of caselaw defining permissible probation conditions.

There are two kinds of probationary conditions: mandatory and discretionary. They may be specified by statute or left to the imagination and creative impulses of the court and the juvenile probation officers on which it relies.

Mandatory Conditions

Most states' laws provide for relatively few mandatory conditions of juvenile probation. All, however, provide: 1) that probationers may not commit a new delinquent act, either local, state or federal; 2) that probationers must report, as directed, to their probation officer; and 3) that probationers must obey all court orders. Some states add mandatory probation fees which must be paid by the juvenile. There are also mandatory conditions pursuant to specific acts. For example, drunk drivers, in order to prevent license loss, are often required to enter and complete alcohol education and treatment programs.

Discretionary Conditions

State statutes may provide a "laundry list" of various discretionary conditions from which the court may choose. The New Jersey Juvenile Statutes A:4A-4B provides a detailed example. It allows the court to place a child on probation, on the condition that the juvenile, among other things:

- pays a fine;
- makes restitution;
- performs community service;
- participates in a work program;

- participates in programs emphasizing self-reliance, such as intensive outdoor programs teaching survival skills, including but not limited to camping, hiking and other appropriate activities;
- participates in a program of academic or vocational education or counseling which may require attendance after school, evenings and weekends;
- be placed in a suitable residential or nonresidential program for the treatment of alcohol or narcotic abuse;
- be placed in a nonresidential program operated by a public or private agency, providing intensive services to juveniles for specified hours, which may include education, counseling to the juvenile and the juvenile's family if appropriate, vocational counseling, work or other services;
- be placed with any private group home (with which the Department of Correction has entered into a purchase of service contract).

The New Jersey statute also allows the court to impose conditions on the juvenile's parents. While only a dozen states have such statutes, some jurisdictions have reached the same conclusion by court decision, ruling that juvenile court judges may make such parental orders enforceable through their inherent authority to hold nonconforming parties in contempt. The New Jersey statutory language allows the court to order the juvenile's parents or guardians to participate in appropriate programs or services when the court has found either that such person's omission or conduct was a significant contributing factor toward the commission of the delinquent act, or, under its authority to enforce the litigants' rights, that such person's omission or conduct has been a significant contributing factor towards the ineffective implementation of a court order previously entered in relation to the juvenile.

The New Jersey laws also provide for detention of the juvenile for up to 60 days in addition to the community-based probation, and, like an increasing number of other states, allow the judge to revoke the juvenile's driving license as an additional condition of probation.

Other statutes may list additional specific alternatives. However, with one or two exceptions, these other state laws add the same general condition as does New Jersey: The court may "order that the juvenile satisfy any other conditions reasonably related to the rehabilitation of the juvenile." This means that the juvenile probation officers are not restricted in their recommendations to the court, nor is the court limited to imposing only those conditions enumerated in the jurisdiction's statutes.

Standard Conditions

Generally, most departments maintain a set of standard conditions for the specific state, county or court jurisdiction. These are usually a combination of those conditions mandated by law and those discretionary conditions the jurisdiction has decided to uniformly impose. Most departments maintain their own standard Conditions of Probation forms. These forms usually leave blank lines for additional discretionary conditions to be included as ordered by the court. The general principles described here are applied consistently throughout the county and reflect the current state of caselaw.

Setting Conditions

Conditions Must be Do-Able:

In addition to being reasonably related to the offense, the offender's rehabilitation or the community's protection, probation conditions must be do-able. For example, a borderline retarded juvenile probationer can not be ordered to maintain satisfactory grades at school^[1]

Conditions Must Not Unreasonably Restrict Constitutional Rights:

While conditions may proscribe a juvenile's constitutionally protected rights, they must do so as conservatively and narrowly as possible while still achieving the desired goal of rehabilitation or crime prevention.

Conditions Must Be Consistent with Law and Public Policy:

Proposed conditions cannot go against public policy or preempt existing specific statutes or contradict their intent. Generally, for example, appellate courts have not approved of the imposition of fines as a condition of juvenile probation. Fines are punitive and the statutory purpose of juvenile probation is generally stated to be rehabilitative. Therefore, fines are seen as inconsistent with juvenile probation law.^[2]

However, these same appellate courts have ruled that the juvenile court may not impose fines but may order equally hefty or heftier restitution orders. Restitution, the courts reason, is not punitive, but rehabilitative and, therefore, consistent with juvenile probation policy and law. Notwithstanding this ruling, many courts do recognize that, while not "primarily punitive," juvenile probation has an "inherent stigma," and restrictions upon the freedom of the probationer have a "realistically punitive quality."^[3]

In a separate decision, the Maryland appellate court has upheld a 1,000 hour community work service order despite a section of its juvenile statute limiting the ordering of community work service to 20 hours for first offenders and 40 for second. While this decision would seem to go against the principle defined in this section, the appellate court ruled that another section of the same juvenile code allowed the judge to impose reasonable conditions to promote the goals of probation. Pursuant to that section of the law, the court found the order of 1,000 hours of community service to be lawful.^[4]

Juvenile probation officers must be mindful of the general premise underlying the disposition of juvenile cases in assessing the consistency of their probationary recommendations with public policy. That premise is that the juvenile court should choose the least restrictive alternative.^[5]

Conditions Must Be Specific and Understandable:

Conditions must be intelligible and understood by the probationer. Typically, in the old days, standard conditions included such prohibitions as "refrain from associating with persons of bad character." Such conditions have generally been ruled to be too vague to be enforceable.

Notice of Conditions to Probationer:

Once probationary orders are made by the court, they must generally be committed to writing and given to the probationer.^[21] Obviously, if the juvenile is unable to read, simply writing the conditions is not enough. The juvenile probation officer must be careful to explain them thoroughly and clearly to the juvenile and his parents or guardians to insure that the child understands his obligations.

Probation Revocations:

If the probationer violates any condition of probation, the probation officer may send him notice to appear in court or arrest him and bring him to court for a hearing. The hearing is generally called a "revocation hearing," but because the probation officer is surrendering the probationer to the court for a violation of probation, the hearing is sometimes referred to as a "surrender hearing" or a "violation hearing."

Case Law for Revocation:

A Michigan appellate court has ruled that the juvenile revocation hearing "requires only that a certain procedural format be followed ... the hearing is conducted only to determine whether the probation has been violated; the hearing does not result in a conviction of the underlying crime." That court concluded: "We find that only a dispositional hearing was required before revoking appellant's probation; furthermore, we find that such a procedure is not violative of appellant's due process rights."^[22]

Despite the fact that the revocation hearing is not as formal as a new trial, the juvenile is still afforded limited rights of confrontation and protection against the undue use of hearsay evidence against him. For example, a Texas appeals court ruled that a juvenile's probation could be revoked for the juvenile's truancy; however, where the revocation was based on the unsworn testimony of the child's probation officer, where the juvenile was given no opportunity to review any written data, reports or records from which the probation officer testified, and where no opportunity was given the juvenile to rebut the testimony, the juvenile was not given the essentials of due process and fair treatment.^[23]

Hearsay evidence, however, may be admissible in revocation hearings; also there is no privilege in the juvenile's communications with the probation officer.^[10]

Sentencing Probation Violators:

Once a violation of probation has been found, the court must decide what to do. The court has the same discretion it had when the juvenile was originally adjudicated delinquent. It may simply admonish the juvenile and maintain the current probation, it may modify the probation conditions or it may revoke the probation and commit the juvenile in accordance with the law.

Bringing a case forward after a violation has occurred should be considered part of the supervision process. It can be a tool to insure adherence to behavioral norms required of the juvenile. It is not uncommon for probation violations to occur, therefore, it need not be seen as a "defeat" or admission of failure on either the probationer or probation officer's part. Therefore, the probation officer's recommendations should not, and need not be, all or nothing. The probation officer should recommend just what is needed to produce the juvenile's compliance with his probation and no more. An order of community work service or a curfew restriction, for example, may be enough to convince the juvenile that probation is serious. Long term commitments may not be necessary for the first or second violation. Some jurisdictions have developed short, "shock" detention for first or less serious violations. For example, Hennepin County in Minnesota has a program of weekend detention for probation violators called "Quick Stop."

Footnotes

[1]

In Re Robert M., 163 Cal. App. 3d 812, 209 Cal. Rptr. 657 (1985).

[2]

State in Interest of M.L. 317 A.2d 65, 64 N.J. 438 (1974).

[3]

State in Interest of D.G.W., 361 A.2d 513, 70 NJ 488 (1976).

[4]

In re Shannon, 483 A.2d 363 (Md. App. 1984).

[5]

State ex rel. R.S. Trent, 289 SE2d 166 (W.Va. 1982); In Interest of W.E.G., 342 NW2d 900 (Iowa App. 1983); State in Interest of Bellow, 461 So. 2d 1127 (La. App. 1984); State v. Myers, 22 NW2d 199 (N.D. 1946); Matter of Welfare L.K.W., 372 NW2d 392 (Minn. App. 1985).

[6]

Matter of Bakley, 328 SE2d 831 (N.C. App. 1985).

[7]

Mass. Gen. Law, ch 276 Subs. 85.

[8]

Matter of Scruggs, 350 NW2d 916 (Mich. App. 1984).

[9]

Matter of J.B.S., 696 SW2d 223 (Tex. App. 1985).

[10]

Matter of L.J.M., 473 NE2d 637 (Ind. App. 1985).

TIP 21: Appendix G - "Multicultural Awareness: Developing Cultural Understanding in the Juvenile Justice System"[1]

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OJJDP

Office of Juvenile Justice and Delinquency Prevention

Juvenile Probation

Multicultural Awareness: Developing Cultural Understanding in the Juvenile Justice System

by Imogene M. Montgomery, Research Assistant, National Center for Juvenile Justice

The purpose of this monograph is to underscore the importance of including a multicultural perspective in the processing of juveniles through the juvenile justice system and to provide some practical approaches and recommendations for achieving an awareness and sensitivity to different cultures. In addition, it is an effort to decrease miscommunication and enhance interaction between practitioners and juveniles thereby reducing the negative impact that cultural diversity may have on decision making.

The need for a multicultural perspective in the juvenile system arose in part because of the increasingly disproportionate incarceration rates of minority juveniles nationwide. Research on the matter indicates that the attitudes, perceptions, prejudices and biases of system officials may be related to the problem. Kratcoski and Kratcoski (1990) indeed found this to be true. They indicate that the type of training and personal prejudices and opinions of police officers affected the way a juvenile's case was handled. In addition, the youth's attitude race, sex, and

social class affected case processing. Other practitioners, too, may unwittingly allow negative perceptions to influence how juvenile cases are handled. Because of this, it is important to develop mechanisms that ensure that personal attitudes and perceptions do not adversely influence decision making. This can be accomplished by increasing one's knowledge, empathy and respect for cultural diversity.

The recent movie, "Dances with Wolves," emphasizes the need to learn about different cultures. In the movie, Kevin Costner portrays a Union soldier on the frontier who is at first frightened by his confrontations with the Indians. By the end of the movie, the culture and language he thought strange had become a part of him. He learned to value and respect the Indian culture = to embrace it as his own. In essence, that is the purpose of multiculturalism: to learn about other cultures, to recognize and understand their differences, and to value and respect them for being different.

In real life we live in a multicultural and multilingual society. We see and interact with Asians, African Americans, Hispanics, Native Americans and people of many other nationalities. As a result, we must create an environment where we can work, serve, educate and communicate with culturally diverse people. We can do this by increasing our knowledge, understanding and respect for other cultures - by noting our differences and learning how to work with one another. This can be done through awareness training, which is an effective method of promoting multicultural understanding.

Culture refers to a set of beliefs, values, arts, mores, habits and customs held by a specific group of people. These groups may include ethnic, racial, religious, professional and social groups. Therefore, not only do Hispanics, African Americans and Asians have distinctive cultures, but youth gangs, senior citizens, divorcees, and juvenile probation officers do also. An expanded definition of culture is given by Porter cited in Nadler et al. -- *'(c)ulture involves the cumulative deposit of knowledge, experience, meanings, beliefs, values, attitudes, religions, concepts of self, the universe, and self-universe relationships, hierarchies of status, role expectations, spatial relations, and time concepts acquired by a large group of people in the course of generations through individual and group striving' (1985:89).*

In addition the patterns of our culture influence the way we communicate and interact with others. As a result, we may tend to feel that our own culture is correct and other cultures are not as reflected in this statement by Nadler and his colleagues: *An individual's value system significantly affects that person's perception of a situation...the more an individual fundamentally accepts a basic system of values, the more he is likely to view his own interpretation of an act as the morally correct one and the other fellow's as falling short of grace (1985:89).*

This attitude exemplifies the notion of *ethnocentrism*, which is the belief that one's culture is superior to another. Therefore, a critical aspect of awareness training includes that of self discovery. This involves the need to observe the self in relation to other cultures and to critically analyze one's perceptions of others.

Multiculturalism challenged the concept of the *melting pot* in which people of different ethnic and racial backgrounds gave up their traditions and heritage to assimilate into American culture. Today, the *melting pot* is gone. People with different cultural backgrounds no longer decide to shed their identities; instead they take pride in them. That pride is a characteristic of multiculturalism, which says that the ethnic, racial and social identities of American citizens should be valued, studied and respected in their own right. In other words, to be different is okay and worthy of appreciation and respect. That is the difference with the new wave of multiculturalism. People are concerned about cultural differences and are identifying ways to accommodate them.

Multicultural awareness is impacting school curriculums. for example, in Dade County, Florida, students represent 123 different countries. In New York, 1 out of 4 children under age 10 have nonEnglish speaking parents (TIME Magazine, 1991). Multiculturalism is also beginning to affect the future labor market. According to *US News and World Report* and *Work Force 2000*, the increase in the ethnic population will lead to critical changes in labor management. A major change will be in the development of supervisory skills. Managers will need to be skilled in working with culturally diverse people and developing sensitivity to differences in others. This new type of manager is predicted to be one of the top twenty career positions of the future.

Changes adopted by education and labor suggest that the juvenile justice system must also begin to accommodate the needs of the growing ethnic population.

The Multnomah County Juvenile Justice Division in Portland, Oregon is a unique example of a juvenile justice system that has begun this process. The Division developed a systematic plan to incorporate cultural awareness activities into its' entire operation. Efforts to increase awareness of cultural diversity arose in response to a concern for the increasing numbers of minority youth committed to state institutions. It was determined that hiring and retaining a multicultural staff that reflected youths in the system were important ways to address the problem. In addition, the Division required awareness training for **all** staff members to increase the system's ability to work with a culturally diverse population. These training sessions are provided by a number of qualified professionals.

The intentions of Multnomah County Juvenile Justice Division to increase numbers of minority staff and to increase awareness skills of all staff led to the development of a Five Year Diversity Plan in July 1991. Implementation of these goals are currently underway. The following are the goals of the Five Year Plan.

Goal 1. Promote an environment which attracts, retains and fosters a diverse and multi-cultural staff.

Goal 2. Facilitate and encourage cross-cultural communication within the Division.

Goal 3. Ensure the development and implementation of cross-cultural diversity, knowledge, empathy and respect in policy, planning and service delivery systems within the Division.

Goal 4. In partnership with the service provider community and in the community at large, seek and receive knowledge, information and resources from the community to improve our knowledge, empathy and respect of the various community collectives.

Goal 5. Provide bold and innovative leadership through advocacy for diversity and cross-cultural knowledge, empathy and respect in the service provider community and in the community at large.

Recognizing Cultural Differences

The goal of multiculturalism is to increase knowledge, awareness, empathy and respect for different cultures. Practitioners need to be culturally aware in order to increase their effectiveness in their jobs and to reduce conflicts, misunderstandings and most importantly, stress. In recognition of the increasingly disproportionate incarceration rates of minority youths, multicultural awareness is also needed to reduce potential bias in decision making.

Practitioners can begin to increase their awareness by learning about the verbal and nonverbal communication styles of different cultures. These differences may influence the way the practitioner responds to a juvenile due to a lack of knowledge about the meaning of the verbal or nonverbal communication in that culture. The verbal communication of a culture may be direct ((assertive) or indirect (nonassertive), boisterous or silent (Gudykunst, et al., 1988). For example, in Asian cultures, there is a tendency to be less assertive in speaking and to be indirect. However, in African American cultures verbal communication appears to be assertive. There is a tendency to talk loudly and use "street talk" when communicating with each other. As a result, practitioners from Hispanic or white cultures should avoid adopting the African American's verbal style in one-to-one communication; it may adversely affect the practitioner's credibility (Cesarz, 1991).

Still another difference can be found In Hispanic cultures, where dialogue may sound more intimidating than it actually is. This may be attributed to the language difference. The fact that English is a second language in this culture suggests that practitioners need to be aware of the tone and inflections used in a culture's language (Cesarz, 1991). Practitioners should be aware that juveniles from African American, Asian or Hispanic cultures who exhibit these verbal styles are simply reflecting the patterns of their culture not reacting to the practitioner personally.

Therefore, the perception that the juvenile's loud, boisterous or intimidating communication style is disrespectful, may be simply a matter of cultural differences.

Nonverbal communication also varies among cultures. Some cultural groups convey messages by using more nonverbal behavior than verbal communication. For example in Hispanic cultures *machismo* is a value in males which conveys a strong self-image. It is characterized by stares, silences and an air of "coolness." *Machismo* is valued in Hispanic cultures and explains why men resist taking orders from non-Hispanics and women. If the practitioner is a woman, she should declare her official role in the first meeting with the Hispanic juvenile. This will increase her credibility and reduce future resistance. Because of the value of *machismo* in Hispanic culture, practitioners should beware that one-to-one direct communication works best when dealing with members of this cultural group (Cesarz, 1991).

In Native American cultures, stares and silences are used to convey different messages. A firm look indicates seriousness and maintaining eye contact is a sign of disrespect (Cesarz, 1991). In Asian cultures, silences are used to emphasize meaning and to show power (Gudykunst et al., 1988). Eye contact is also viewed by Hispanic and African American cultures as a sign of disrespect. In white cultures, direct eye contact conveys trustworthiness, forthrightness and sincerity (Hanna, 1988). If the practitioner is white, lack of eye contact may viewed as lacking integrity.

There are also differences in the amount of touching within a culture. In Hispanic and African American cultures, handshaking, slapping hands or hugging tends to be used for added expression (Gudykunst et al., 1988). In white cultures, touching or closeness when speaking may be viewed as an invasion of space (Hanna, 1984).

Practitioners should also be aware of what is valued in a culture. In some cultures, religion is highly regarded. For example, in Hispanic Native American and African American cultures there is a great deal of respect for religion and spirituality. With this in mind, the practitioner may seek assistance from the juvenile's minister, priest or spiritual leader when handling juveniles from these backgrounds (Bailey, 1991).

In addition, practitioners should be aware of the value of family among different cultures. In Hispanic, Asian, and African American cultures family relationships are highly regarded. In Hispanic cultures, *carino*, dignifies caring and protection of each other in the family (Bailey, 1991). In Asian cultures mutual support, cooperation, interdependence, family pride and honor are valued. Problems in Asian cultures are generally handled within the family and outside influences are unwelcome. In African American cultures, the family consists of extended households that are frequently headed by an older woman. A mutual aid system is common in African American cultures - welfare of the family in these extended households is a primary obligation (Selected Cultural Contrasts). Practitioners should consider the value of the family unit and consult with family members, religious leaders or other authority figures when in contact with juveniles from these cultural groups.

The cultural differences presented here are general characteristics that have been observed in some groups. However, practitioners should keep in mind the following basic facts about culture when they encounter juveniles from different cultures.

- Cultures continue to change;
- Cultural differences are related to (and affected by) economic status, education, age, region, and sex;
- Cultures and members of a culture should not be stereotyped (Wright, 1991).

Practical Ways for Increasing Cultural Awareness

An important way to become familiar with the communication styles of different cultures is by using role play exercises. Role plays can increase awareness and tolerance of other cultures. In a role play, the practitioner can be taught to recognize the differences in verbal and nonverbal communication and to respond with attitudes and behaviors that encourage communication and acceptance. This is accomplished by age communication and acceptance. This is accomplished by the practitioner playing the role of the juvenile. Roleplays should be done in a controlled setting and directed by a trained professional. One example of a role play places the setting for the

exercise as the first encounter between the juvenile and the practitioner (Moriarty, 1991). The practitioner acting as the juvenile should be instructed to be loud, to use street slang and to avoid eye contact with the practitioner. The practitioner should be allowed to respond without any cues. The purpose of this role-play exercise is to allow practitioners to note the non-verbal signals and gestures of the juvenile and the responses of the officer. Practitioners in the group can then discuss the interaction.

Practitioners can also develop sensitivity toward juveniles from other cultures by examining their own feelings and perceptions about cultures and by reading and studying the history and literature of different cultures. In addition, the following steps may be adopted for use when handling juveniles from culturally diverse backgrounds. They were adapted from "State of the Art Nonverbal Behavior in Intercultural Counselling," by Aaron Wolfgang. The first recommendation is to: *Try to avoid dealing with the problems of culturally different juveniles from your desk, i.e. preoccupying yourself with administrative duties, showing little interest, or being superficial.*

Showing noninvolvement with your cases is a major obstacle to effective performance. Behaviors practitioners may use that show noninvolvement include: avoiding eye contact, keeping social distance and showing facial expressions that are either neutral or negative. A second measure that practitioners can incorporate into their daily routines which may build a rapport with the juvenile is to: *Try to like the juvenile whose culture is different from your own. Show an interest in the juvenile.*

Some examples of showing that you are interested in the juvenile include: smiling, positive head nods, or forward body leans. These behaviors have to be careful not to be overdone or they will be viewed as forced or faked. Finally practitioners can enhance the interaction with juveniles if they: *Try to understand and see the value of the juvenile's culture, the lifestyle, and the values important to that culture.*

This will require some major effort on the part of the practitioner, but the results will be well worth it. Practitioners will need to be flexible, willing to change preconceptions of a culture, willing to accept cultural, ethnic and racial differences, and willing to overcome any belief that

their own culture is superior. The behaviors that practitioners can use to show they understand include: expressions of warmth, positive involvement, and confidence.

The practitioner who takes the time to learn about different cultures will be an asset to the profession by helping juveniles recognize the strengths and weaknesses of both cultures, and by helping them develop competency skills to get along in different situations. Being sensitive to cultural differences enables positive relationships between the practitioner and the juvenile.

Cultural Awareness Training

In addition to the efforts of the Multnomah County Juvenile Justice Division to increase cultural awareness, the National Center for Juvenile Justice has developed a cultural awareness training module as part of the *Fundamental Skills Training for Juvenile Probation Officers*, funded by the State Justice Institute. The training module is designed to be used by trainers to sensitize juvenile probation officers to the verbal and nonverbal communication differences that are related to culture. The curriculum, entitled *Appreciating Cultural Diversity* was created by Vicki Wright, Director of Training and Staff Development, Texas Juvenile Probation Commission. Through this effort the communication and job skills of the practitioner will be greatly enhanced. In addition, the possibility that bias will be a factor in juvenile case processing is likely to be reduced.

The training module begins with a general introduction and discussion of culture and race. Also included is a role play exercise which underscores the importance of an individual's perceptions of a culture and how nonverbal communication is critical to the understanding of a specific culture. The conclusion of the training module focuses on a discussion of the audience's perceptions of the role play as well as the perceptions of those who participated in the exercise. The entire module gives further credence to the need to consider the whole picture when we serve, work and communicate with others who are different from ourselves.

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For information about the cultural awareness training module contact Vicki Wright, Director of Training and Staff Development, Texas Juvenile Probation Commission, P.O. Box 13547, Capitol Station, Austin, TX 78711. (512) 443-2001

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TIP 21: Appendix H—Prospectus for a Consensus Development Panel

Combining Alcohol and Other Drug Abuse Treatment with Diversion for Juveniles in the Justice System

Overview

The incidence of crimes associated with abuse of alcohol and other drugs (AODs) among adolescents is a national concern. The prevalence of violent crime committed by youth gang members has increased significantly during the last decade. Children and adolescents are adjudicated as adults in many jurisdictions for a range of violent and nonviolent offenses. Many children and adolescents involved with the justice system commit offenses following their abuse of alcohol, inhalants, marijuana, cocaine, and other drugs—all of which are readily available in their communities, schools, and often their homes. Parent groups, community leaders,

lawmakers, the justice community, educators, and AOD abuse treatment providers are trying to solve the problem.

In many States, juveniles who commit violent offenses are waived into the adult system, tried as adults and convicted. They are sentenced as adults and serve their sentences in adult prisons. They may have virtually no involvement with the juvenile justice system. Therefore, children and adolescents committing lesser offenses, which are often related to their abuse of alcohol and other drugs, require special intervention. Such intervention may prevent them from eventually committing violent or adult offenses. This intervention may include comprehensive substance abuse disorder treatment that, typically for juveniles, includes their family members. The involvement of family members may be enhanced if the systems provide services that recognize the specific cultural and ethnic needs of the affected juveniles and their families.

Justice systems that include interventions that provide rehabilitative conditions for juvenile offenders and their families can work to divert from the justice system a population of young offenders who are at risk of committing criminal acts associated with their substance abuse disorder. The juvenile justice field has great need for such interventions with youth who are initially status offenders or who have experienced previous adjudication for lesser offenses and are at significant risk of criminal activity. Interventions for this population are complicated by existing State and Federal confidentiality regulations.

Effective treatment of substance abuse disorders among adolescents requires a comprehensive approach that incorporates family and health issues. A holistic approach to the treatment of adolescents may obviate their future involvement in status offenses or other delinquent or criminal activity. The risk-taking behavior typically associated with adolescence is exacerbated in the adolescent who is abusing alcohol or other drugs. This combination of high-risk behaviors and underlying causal factors frequently place adolescents of both genders at of infection and transmission of diseases because of injecting-drug use (IDU), use of unsafe sexual practices, and exchange of sex for drugs.

State systems choosing to provide juvenile diversion services need to address quality concerns within the juvenile justice and the AOD abuse treatment systems. If the systems are to work collaboratively, they need to identify treatment capacity expansion and treatment improvement issues. They also need to agree on the collective measures used to implement and ensure services from each system.

Appropriate treatment placement and incentives are significant issues, especially as they involve the family or guardians. In many treatment situations, the family, rather than only the identified juvenile, is considered to be the client. Other examples of such issues are the appropriate role of the justice system and the AOD treatment system in ensuring the public safety, the differences between the responsibility for the punitive and the therapeutic aspects of the diversion process, the responsibilities of each system for screening and assessment, and linkages among systems that provide collateral services such as Medicaid and social services.

Jurisdictions considering juvenile diversion programs may anticipate incurring implementation costs. However, these costs are less when compared with the costs to construct additional youth correctional facilities or to incarcerate juveniles, even without treatment, for the same period of time. In addition, the combined efforts of the justice system and those of the AOD treatment system send a strong and unified message to the juvenile offender about the community's values concerning juvenile substance abuse and criminal activity. The most successful programs will also send a similar unified message to the public about the long-term financial and other benefits of the diversion program and the ways in which it protects the public's safety.

Audience

This TIP will be for an audience comprised of

- Juvenile justice and family court judges, court administrators, probation officers, prosecutors, public defenders, and youth correctional administrators

- AOD abuse treatment providers such as counselors, social workers, psychologists, physicians, and administrators
- Public health providers and administrators
- State social service or welfare child protective services and foster care social workers, family preservation social workers, public safety planners, and system administrators
- State and local school administrators, school counselors, and school or public health nurses.

Purpose

The Center for Substance Abuse Treatment (CSAT) will convene a consensus panel to develop guidelines for diversion of juvenile offenders who abuse AODs. The resulting guideline, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System*, will build on two extant TIPs on adolescents. They are *Screening and Assessment of Alcohol and Other Drug Abusing Adolescents* and *Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents*.

The TIP will contain guidelines that provide a framework for developing coordinated strategies to assist AOD-abusing juveniles who are involved with the justice system. Systems such as juvenile justice, AOD abuse treatment and public health increasingly provide services to the same individual. This document will assist them in developing comprehensive treatment strategies and resource sharing.

Content

The panel will identify the various types of diversion programs beginning at the prosecutorial level and clarify their differences, programmatic components, supervision requirements, and coordination with AOD abuse treatment providers. In addition, the panel will suggest strategies to engage family members in the treatment of children and adolescents and will identify methods that are potentially useful in creating a support network to supplement or compensate for absent

family support. Issues concerning the identification and treatment of infectious diseases will be explored. The panel will address quality improvement issues and provide some specific costs associated with juvenile diversion programs.

The TIP will also include attention to the legal and ethical concerns surrounding Federal and State confidentiality regulations and parental consent. The guidelines will also make suggestions for providing services to special populations such as Native Americans, African Americans, Asian Americans, females, Hispanics, Latinos and Latinas, sexually active minority youth, and others with special needs.

Format

The final product of this activity will be a monograph published by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

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